			1 - For State Registrar	State of Ma	aryland /	-	rtment of I			Re	ig. No. 200	4 1800
10)	Physici	- 4	Decedent's Name (First, Middle, Last)						2.	Date of Death Month	Day Year	
	/Medic			BORROR			th Ch. Taux	a. Lagretion	of Dooth	JUNE 3	4c. County of De	16:20 M
	Examin	er	4a. Facility Name (If not institution, give s	street and number)			4b. City, Town,		or Death			
6.			MEMORIAL HOSPITAL 5. Social Security Number 6. Sex	7. Ag	e (In yrs. last	birthday)	CUMBERI If Under 1 Year	If Under		Date of Birth	ALLEGAN 9. B	irthplace (State or Foreign
Е	Funeral Director]M 2⊠F	84	Yrs.	Months Days	Hours	Min.	(Month, Day, ay 25,	1920 We	country) est Virginia
	р		Usual Residence of Decedent		10-0							10d. Inside City Limits
	srylan show	_	10a. State 10b. County	_	10c. City, To							1 ☐ Yes 2 ☒ No
	8a-f	5	WV Miner	al		Burl	ington				On Citizen of Miles	
	with the	듬	10e. Street and Number	0.0			10f. Zip Code	06710		19	og. Citizen of What (Southly?
	s 23	erai	Rt. 1, Box 2	U8 12. Was Decedent	Ever in U.S.	13 \	1	26710 Hispanic Or	rigin? (Specify	Yes or No-	USA 14. Race - An	nerican Indian,
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Mudical Examiner must be multised at	by Funeral Director	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:		1	Was Decedent of f Yes, specify Cut I ☐ Yes 2 ☑ No			an, etc.)	Black, Wh Specify:	hite, etc.
0	2 ho	ted	15. Decedent's Edu	cation	1	6a. Dece	tent's Usual Occu	pation	et of working		16b. Kind of Busines	s/Industry
218	within 72 ene. than "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Cotlege (1-4or	5+)	life.	DO NOT use retire	ed)	st of Working			
7	filed with Hygiene. other than	S	4			H	omemaker	40.34.15			Own 1	Home
Maryland	be fill tal H od ott	Be	17. Father's Name (First, Middle, Last)								Maiden Sumame)	
3	should nd Men marke umaric	ဥ	Weldon Deer Hedr 19a. Informant's Name/Relationship (Ty			10h Mailir	an Address (Street				esselrodt City or Town, State	Zin Code)
Na	d 2 st		Curtis J. Borror/							ncton.		
	1 an Heal tem 2		20a. Method of Disposition	2011	20b. Place	e of Dispo	1, Box sition (Name of		Date		20c. Location - City	
D L	Pages nent of I int: If it		1 XBunal 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	_	· _	natory or other pla	1	June 7 2004		Burlingto	- LIV
Baltimore,	entre entre		21. Signature of Funeral Service Licens	0 0	POLL		amily Cer Name and Addr				eral Home	D. W.V.
ñ	Deperminant in the control of the co		> Brian 7	Aug	方		Rt. 2,	Box 1				6710
	6.		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ications that cause ne cause on each l	d the death. (Do not ent	er the mode of dy	ing, such as	s cardiac or re	espiratory arre	est,	Approximate Interval Between Onset and Death
7	Pnysician /Medical		disease or condition resulting in death)	Due to (on s	a consequen	ice of):						1 week
	Examiner		Conversion to the first conditions	Gangi	rene	of	both	fee	+			Zweeks
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequen	ice of):	0 1	1 ,	1		1-	J
X	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	<u>. Occ (u</u>	a consequen	Ye.	ripher	ral 1	lasci	ulat	Disease	5yrs.
69,	be exician ician burial	ai E		Due to (or as	a consequen	ice or).						
68760,	e Se	0		d								
X 6	death certifica e attending ph ed for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome							23d. Date of o	delivery
Box	atter after	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	1□Live birth 4□Pregnant a			Ectopic pregnant Other (specify)	су			Month	Day Year
P.O.	that the de ed by the detached	hysi	9 Unknown	9□ Unknown								
S, F	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions co					iven in Part	l.	23e. Did tob		to the cause of death?
ıd	w require been sig		Diobetes Mel	litus	1460	I 3	<u> </u>			1 🗆 Ye	s 2 □ No 3 📆	Probably 4 Unknown
ecc	e law re has be je 2 sh	pie	Chronic Rena	1 Fail	ute					24a. Was a autops	y prior t	autopsy findings available o completion of cause of
E .	The age	Completed								perform 1 ∐ Yes 2		
/ita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:					ce of Death (C	Check only on	e)	
of	Physic this can dire	2	1 Yes 2 No 27. Manner of Death	1 Inpati 28a. Date of Inj	ent 2 ☐ ER	VOutpatier Bb. Time o	IL 3 LI DOA	-			ence 6 Other (Spow injury occurred	pecify)
Division of Vital Record	ding h. Atter fune	Certification:	1 Natural 5 ☐ Pending	(Month, Da	y Year)	Injury	W	ork? ⊒Yes 2.⊑		2. 00301100 110	ow injury occurred	
isi	Attending r death.	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of In	jury - At home	e, farm, st	eet, factory, office		28f			Rural Route Number,
ă	al or after after I Dire	erti	4 Homicide	building, e	tc. (Specify)					City or Town	i, State)	
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exami	sician: To the best iner: On the basis and manner s	of examination	edge, deat n and/or in	h occurred at the vestigation, in my	time, date a opinion, de	and place, and eath occurred	d due to the ca at the time, d	ause(s) and manner ate and place, and o	as stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	A			29c. Licer	nse number		2	9d. Date signed (Mo	onth, Day, Year)
•			> MATACAN	1/100			D19	318			June	412004
	0		30. Name and address of person who co	o word use of	death (Item 23	За) (Туре,						, a
			RANJITHAN, N.A.,				OAD, CUM	BERLA	ND, MD	21502		
	St. Regist		31. Date filed (Month, Day, Year)	32. Regist	rar's Signatur	e 	1					
DI	MH 17 Rev 1/2		1 JUN 0 8	2004	TORING.	15	E MARIE					

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryland		rtment of I			iene	11. 19000
	Physic /Medi Exami	cal	Decedent's Name (First, Middle, Last) ESTER 4a. Facility Name (If not institution, give street)		BR	0 W N 4b. City, Town, o	or Location of Dea	2. Date of Deat Month	41.28 454	4 1.45 AM
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. Ia		JOPP If Under 1 Year Months Days		8. Date of Birth	HARF (1951 M	OR D irthplace (State or Foreign Country) I ARYLAN D
	within 72 hours after death with the Maryland ene. then "natural", or fems 23a or 28a-f show the Medical Examinat must be notified at	Director	10a. State 10b. County MARYLAND HAR FOR 10e. Street and Number	D Jo	PPAT	10f. Zip Code		10	0g. Citizen of What (10d. Inside City Limits 1 ☐ Yes 2 XNo Country?
336	s 1 and 2 should be filad within 72 hours after death with the Maryla f Health and Mental Hygiene. item 27 is marked other then "natural", or Items 23a or 28a-1 show other then "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examinations! Let rediffed at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 Keyes 2 No If Yes, Give Year or Dates:		Z 10 € Vas Decedent of I Yes, specify Cub	dispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Arr Black, Wh	
21215-0036	td within 72 hou giene. er then "natura , the Wediesile.	Completed	15. Decedent's Educat (Specify only highest grade of	ion	(Give I life. D	ent's Usual Occup kind of work done O NOT use retire	during most of wo	nrking	16b. Kind of Busines.	
Maryland	2 should be file and Mental Hy is marked oth sumatic event	To Be (17. Father's Name (First, Middle, Last) LESTER L. Br 19a. Informant's Name/Relationship (Type,	ROWN; SR		a Address (Street	MAT	me (First, Middle, M Route Number,	1	4
altimore, M	permit. Pages 1 and 2 should be filad within Department of Health and Mental Hygiene. Importent: if item 27 is marked other then any injury or other traumatic event, Lt. Me Once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	netery, crem KWOD	ition (Name of atory or other place CEMETE	CAY 6/8	Date 2		, M ARYLAND
. Ba	**************************************		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of	ions hat caused the death.	88	Name and Addre	ARFORD	RD. PA	RKVILLE,	MEMORIES MD 21234 Approximate Interval Barween Opset and Death Approximate Interval Barween
	/Medical Examiner	ner	disease or condition resulting in death) a Sequentially list conditions, if any, leading to immediate	Due to (or as a consequent		earjic	Can	WL		8 worths
8760,	cate ba executad hysician and the burial-transit	dical Examiner	cause. Enter Underlying Cause Les according that initiated events resulting in death) Last d	Due to (or as a consequen	nce of):				:	
P.O. Box 6	The law requires that the death cartific tie has been signed by the attending p vage 2 should be detached for use as i	Physician/Med	in the past 12 months?	If yes, outcome of pregnanc Live birth 2 Fetal de Pregnant at time of deal	eath 3□E	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions contrib	uting to death but not resulting	ing in the und	derlying cause give	en in Part I.	23e. Did toba		o the cause of death?
Vital Records,		Be Completed	25. Was case referred to medical examiner?				26. Place of Dea	24a. Was an autopsy perform 1 Yes 2	prior to death? No 1 ☐ Yes	utopsy findings available completion of cause of
Division of \	ting Phys	ို	1 Yes 2 No Hospi 27. Manner of Lath 1 Natural 5 Pending Pendin	28a. Date of Injury (Month, Day Year)	VOutpatient Bb. Time of Injury		4 Nursing H	ome 5 A Residen 28d. Ses ribe how	ce 6 □Other (Spe	icity)
Divi	Hospitel or 4 hours afte Funeral Diri ely filled in b	Medical Certifi	4 Homicide determined 2 29a. Certifier 1 Certifying Physicia	28e. Place of Injury - At home building, etc. (Specify) an: To the best of my knowle On the basis of examination and manager stated.	adge death	accurred at the time	ne, date and place	City or Town,	(-)	
	To the To the To the Complete	_	29b. Signature and titlerof certified	LMD		29c License	number 149		1. Date signed (Month	
	Star Registra	е	30 Name and address of person who complete the CART (50) P = E = 1. Date filed (Month, Day Year) JUN 0 8 2004	eted cause of death (Item 23	240	W. B.	Elveden	EAVE.	BAKimo	NE MD 21215

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ARGARET ANKARD HIERER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street and number) Examiner 7. Age (In yrs. last birthday) IOWSON DALTIMORE ARF ANOR If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year Months Days Birthplace (State or Foreign Country) ARYLAND 6. Sex **Funeral** 1 □ M 2 🕱 F .01.05 Director Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter death with the Meryland Depertment of Health and Mentel Hygiene. Important: if Item 27 is marked other than "naturel", or Items 23e or 28e-1 show any Injury or other traumatic event, the Medical Examinar must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND BALTIMORE PARKVILLE 1 ☐ Yes 2 No Funeral Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 DLLINSDALE)5A 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: WHITE Completed by 3 Nidowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RETARY 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PLAENKER BARBARA JEORGE CHIERER 19a. Informant's Name/Relationship (Type, Print) DAUGH. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BANKARD QUINAN 35 LERNER CT., BARBARA E. TIMORE MD Baltimore, 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MORELAND MEMORIAL PARK 6/9/04 PARKVILLE 22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 21. Signature of Funeral Service License 23a. Part! Enter the disease or complications that caused the shock, or heart failure. List only no cause on each line. HARPORD ROAD Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) by Physiclan/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificete has 1 Yes 2 DA 1 ☐ Yes 2 ☐ NO Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA edicai Certification: To Other: 4 ☑ Norsing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 1 No this : After this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation death. I Director: A 1 ☐ Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours e To the Funerel C completely filled To the Hospital 1 Destritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only ona) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20E Timoniun 1 monium , MD 21093 SuHe Registrar's Signature

DHMH 16 Rev 6/95

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 5 Day Year Janice Clarice Bronson Battle 30 04 10:06p M /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3247 Pelham Street Baltimore
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Birthplace (State or Foreign Country) Days Hours Year 1 □ M 250 F Min. Yrs. Director 261-08-7205 8-10-52 Fla. Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 28e-f show 10d. Inside City Limits ust be notified at Director 1 Yes 2 □ No Baltimore Md. NA 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or USA 3247 Pelham 21213 St. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after ☐Yes 2☐No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced Specify: Black "naturel", Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Film Library Union Mem. Hosp. 2 yrs. 12th grade other! 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill thent of Health and Mental Hitant: If item 27 Is marked oth 18. Mother's Name (First, Middle, Maiden Sumame) ပ Colson Thelma Bronson Charles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is eny injury or other trau 21206 5745 Utrecht Rd., Baltimore, Md. Son Carmeron Battle 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 6-7-04 Owings Mills, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 um March F.H. East 1101 E. North Ave. 23a. Part 1. Enter the disease, or expirications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYPERTANSIVE Physician disease or condition resulting in death) t461725 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical the IF FEMALE esn : 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy φ in the past 12 months? 4☐Pregnant at time of death Month Year 5 Other (specify) the 9 Unknown þ Part II, Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ funeral director, page 2 should Be Completed 1 ☐ Yes 2 ☐ No. 3 Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: Certification: To 4 ☐ Nursing Home 5 € Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pendina investigation 1 ☐ Yes 2 ☐ No after death Director: / filled in by the 6 Could not be determined 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3/04 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who, NEXTH CALVANT STAKET, PARTIMENE, and 21218 m.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

JUN 0 8 2004

Brown & Sparks

		1 - For State Registrar				artment of tificate of			Reg. No.	200	1000
Physici /Medic		1. Decedent's Name (First, Middle, L Ethel Leona Ba						2. Date of De June	Day	200 ^{Year}	3. Time of Death 2:15 a
Examin		4a. Facility Name (If not institution, g LongView Nursin	ive street and number g Home)			or Location of De chester		C	County of Deat	h
uneral irector		171-24-7474	Sex 7. A 1 □ M 2026F	ge (In yrs. Ia 90	ast birthday) Yrs.	If Under 1 Yea Months Day			th Yeard	914 9. Bint	hplace (State or Forei untry Land
fshow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Carrol	1		, Town or Lo						10d. Inside City Limi
3a or 28a at be notif	i Direc	10e. Street and Number 1738 Fairmount	Rd.	1		10f. Zip Code)7 ⁴			zen of What Co	untry?
Important: If liem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Exacts or must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ₺ Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?		Was Decedent of Yes, specify Cu		(Specify Yes or No erto Rican, etc.)		14. Race - Ame Black, White Specify:	
than "natura the Medical E	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education trade completed) College (1-4or	5+)		lent's Usual Occi kind of work don DO NOT use retir Sales C	upation e during most of w ed) Lerk	vorking		ept. St	•
arked other	To Be Co	17. Father's Name (First, Middle, La: Thomas Mays					Carrie	ame (First, Middle, Baublit	, Maiden . Zi	Surname)	
m 27 Is m her traum		19a. Informant's Name/Relationship Ruth Cassell - da		loos pi	1738	Fairmour	nt Rd. Ha	Rural Route Number	Md.	21074	
rtant: If Ite		20a. Method of Disposition 1	pity)		Luthe		June 10		Mano	chester	
any ir		21. Signature of Funeral Service Lic	ensee		33	land an Add	uneral (hapel F.	A. r, M	1. 2110	2
sician edical miner	J.	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	ly one cause on each	ine. Levelo s a consequ	ence of):	os cula	^	c. dat	-		Interval Between Onset and Death 4 works
nysicien and he burial-transit	Icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as								
y the attending physic sched for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ NO 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnan	су		2	3d. Date of deli	very Day Year
an signed b uld be deta	þ	Part II. Other significant conditions	contributing to death I	out not resu	Iting in the un	iderlying cause g	iven in Part I.		obacco us ∕es 2.⊑		the cause of death?
certificate has been signed by the rector, page 2 should be detached	Completed									24b. Were aut prior to c death? 1 \(\sum \text{Yes}\)	opsy findings availat ompletion of cause of 2000
this certil al directo	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 🗆 E	R/Outpatient	3 □ DQA	hor	eath (Check only only only only only only only only		☐Other (Spec	ifv)
ector: After this certificate haby the funeral director, page	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	lry ly Year)	28b. Time of Injury			28d. Describe h			,,
To tha Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 286. Place of in	jury - At hor tc. <i>(Specify)</i>	me, farm, stre	et, factory, office		28f. Location (S City or Tow		Number or Rui	al Route Number,
To tha Funeral Dir completely filled in	Medicai	29a. Certifier 1 Certifying F (Check only 2 Medical Extensione)	Physician: To the best aminar: On the basis of and manner st	of examinati	viedge, death on and/or inv	occurred at the estigation, in my	ime, date and place opinion, death oc	ce, and due to the courred at the time, o	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
To To To	×	29b. Signature and title of certifier	- ~~				se number	-	29d, Date	signed (Month	, Day, Year)
1											

Mary Brown

	04-03	0//	70 Please		_						
	MAN		1 _ For State	State of Maryland / I				d Mental Hy	giene	2001	1000-
			Registrar		Certi	ficate of t	Death		Reg. No	2004	18006
	Physici	an	Decedent's Name (First, Middle, Last,					2. Date of De		Y Year	3. Time of Death
	/Medic		Mary S. Brown					June (06,	2004	0651 A M
	Examir	ier	4a. Facility Name (If not institution, give	*	4	b. City, Town, or	Location of De	ath	4c	County of Death	
			3600 W. Franklin			Baltim				N/A	
	Funeral		5. Social Security Number 6. Sec	711 00=	// N	f Under 1 Year Months Days	If Under 24 H Hours M		th y, Year)	9. Birth	place (State or Foreign
	Director		Usual Residence of Decedent	[™] X ¹ 89	Yrs.			Apr.	2, -	1915 Vi	rginia
	and and		10a. State 10b. County	10c. City, Tow	m or Locat	ion					IOd. Inside City Limits
	dary sh	ō	Delaware New Ca	stle Wilmi	ngto	on					t√⊑Yes 2 □No
	28a	Director	10e. Street and Number			10f. Zip Code			10g Cit	izen of What Coul	4.5
	Sa or		2720 N. Thatche	er Street		19802	2				Hi y r
	be filed within 72 hours after death with the Maryland tal Hygiene. Hygiene. Add other than "naturel", or items 23a or 28a-f show event, the Medical Examinar must be notified at	Funeral		12. Was Decedent Ever in U.S.	13. Was			(Specify Yes or No	USA	14. Race - Americ	can Indian.
0	Ter in the second	교	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give			n, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		Black, White,	
8	el', o	by	3	If Yes, Give Year or Dates:	10	Yes 2 No	Specify:			Specify: Bl.	ack
	2 no natur	Completed	15. Decedent's Edu (Specify only highest grad	ication 16a	Deceden	t's Usual Occup	ation		16b. K	ind of Business/In	dustry
21	Me.	pje	Elementary/Secondary (0-12)	Callera (4. 4a.5.)	life. DO	d of work done o NOT use retired)	vorking			
2	er th	ő	10th grade	Pri	vate	Duty	Nurse		Nu	ırsing	
פ	al H de H	Be	17. Father's Name (First, Middle, Last) John W. Smith				_	lame (First, Middle,			
<u>X</u>		P	DOME W. SMITCH						lor		
Maryland 21215-0036			19a. Informant's Name/Relationship (Ty	rpe, Print) 19b	. Mailing A	Address (Street a	and Number or a	Rural Route Numb	er, City o	r Town, State, Zip	Code)
2° ·	C = 0 P		Emma G. Wells					8₩. Balt			
9			20a. Method of Disposition	20b. Place of cemeter	f Disposition Ty, cremate	on (Name of ory or other plac	e)	Date	20c. Lo	cation - City or To	own, State
E	Pages ment of ent: If it		↓ Burial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)	Dela.	Vet	. Cem.	6-1	10-04	Bea	r, De.	
Baltimore,	permit. Pages Department of Importent: If i any injury or one		21. Signature of Funeral Service Licers	00	22. N	ame and Addres	s of Facility	Chatman-	-Har	ris Fur	neral Hom
	<u> </u>		1 xruy -far	-1					Dar	timore,	Maryland
			23a. Part1. Enter the disease, or compli shock, or hear failure. List only or	ications that caused the death. Do r ne cause on each line.	not enter th	he mode of dying	g, such as cardi	ac or respiratory a	rest,		Approximate Interval Between
4	hysician		Immediate Cause (Final disease or condition	Hypertensive Art	erio	sclerot	ic Card	iovascula	r Di	sease	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):						
		_	Sequentially list conditions)							
3	sit a	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):						
	te be executed ysician and he burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence	-0.						
, 60,	C is o	alE		Due to for as a consequence t	JI).						
189	ettending physical for use as the t	ಲ		j							
×	e ettending phy de for use as th	hysiclan/Med	IF FEMALE:	3c. If yes, outcome of pregnancy							
X R R	etten for u	lan	in the past 12 months?	1 Live birth 2 Fetal death		opic pregnancy her (specify)			2	23d. Date of delive Month	ry Day Year
	2 W Z	ysle	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	3 🗆 01	ner (specily)					
7	requires mat me de been signed by the e hould be detached f	0	Part II. Other significant conditions con	ntributing to death but not resulting in	the under	rlying cause give	n in Part I.	23e. Did to	bacco u	se contribute to th	e cause of death?
ecords,	sign ld be	d by						1 🗀 Y	es 2	No 3 Prob	ably 4 □Unknown
Ö		ompieted						04-146-		\	
ě	has ye 2	mp						24a. Was autop		prior to cor death?	osy findings available npletion of cause of
	certificate	O						1□ Yes	2 No		2 No
Vital		o Be	25. Was case referred to medical examiner?	fospital:		Othe		eath (Check only o			
o	r this	\vdash	1 X Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ EP/Our 28a. Date of Injury 28b. T		DOA	4 🗀 Nursing	Home 5 Resid			At scene
	After thi funeral c	tion	1 Satural 5 Pending		njury	28c. Injury Work M 1 🗆 Y	? ′es 2 □ No	20d. Describe	ow injury	occarred	
0 7	- m - 0	ca	3 Suicide 6 Could not be	28e. Place of Injury - At home, far				28f Location (S	treet and	d Number or Rura	I Route Number
OIS!	deatl ctor: y the		4 ☐ Homicide determined	building, etc. (Specify)	,, 5,,000,	raciory, omce		City or Tow	n, State)	THUINDER OF HUIZI	noute Number,
DIVISION	after des Directo	ertif	- Continues					and due to the			
DIVISIO	ours after desours after des	al Certification;		icien: To the best of my knowledge	death occ	curred at the time				and manner as st	atod
DISINIC	24 hours after de Funeral Directo		29a. Certifier 1 ☐ Certifying Phys	sicien: To the best of my knowledge ner: On the basis of examination and and manner stated.	, death occ dor investi	curred at the timi igation, in my op	e, date and place inion, death occ	curred at the time, of	ause(s) date and	and manner as sta place, and due to	ated. the cause(s)
DINIC	within 24 hours atter der	Medical Certif	29a. Certifier 1 ☐ Certifying Phys (Check only 25 Medical Exemir	ner: On the basis of examination and	, death occ	curred at the timing ation, in my op	inion, death occ	curred at the time, o	date and	and manner as standard place, and due to essigned (Month, L	the cause(s)
DISIO	within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edical	29a. Certifier (Check only one) 1 ☐ Certifying Phys 2 ☑ Medical Exemin	ner: On the basis of examination and	, death occ d/or investi	29c. License	inion, death occ number	curred at the time, o	late and 29d. Date	place, and due to signed (Month, L	the cause(s) Pay, Year)
	1	edical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Exemin	ner: On the basis of examination and and manner stated.	d/or investi	29c. License	inion, death occ number	curred at the time, o	late and 29d. Date	place, and due to	the cause(s) Pay, Year)
DISING	within 24 hours after dea within 24 hours after dea To the Funeral Directo completely filled in by th	edical	29a. Certifier (check only one) 29b. Signature and title of certifier 30. Name and address of person who ee	and manner stated.	Type, Prin	29c. License O.C.N	number	curred at the time, o	date and 29d. Date Jun	place, and due to a signed (Month, Let 06, 20	the cause(s) Day, Year)
DISINIO	1	Medical	29a. Certifier (check only one) 29b. Signature and title of certifier 30. Name and address of person who ee	and manner stated.	Type, Print	29c. License O.C.N	number	curred at the time, o	date and 29d. Date Jun	place, and due to a signed (Month, Let 06, 20	the cause(s) Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Lionel Brown Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Lionel Brown May 24, 2004 06:35 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Hospital Center Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□F Director 06/20/1956 579-74-4169 Wash. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show ral', or items 23e or 28e-f show Exercitive must be notified at 1 TyYes 2 □ No Washington DC Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 20018 U.S.A. 1423 Saratoga Ave. N.E. #5 Funeral 12. Was Decedent Ever in U.S Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be fited within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or lien any injury or other traumatic event, the Medical Evantia 1 Never Married 2 Married Yes 2 No 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 Widowed 4 Divorced Year or Dates: **Black** pa 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Comple Elementary/Secondary (0-12) College (1-4or 5+) 8th Laborer Gray Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Willie W. Brown Cecelia Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1423 Saratoga AVE. NE #5 WDC 20018 Cecelia V. Brown -Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Brown Family Cemetery 05/29/04 Virginia 21. Signature of Euneral Service Licenses 22. Name and Address of Facility Austin Royster Funeral Home 3821 14th ST, N.W. WDC 20011 23a. Part 1. Enter the disease, or complications that caused shock or heart failure. List only one cause on each lir Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory/arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physicien: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of) Box 68760. Physiclan/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 0 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 2/No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2□ No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 2 1XXYes 2 □ No 1 Inpatient 2 X ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 27. Manner of Death Date of Injury y onth, Jay Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 🗌 Pending 1 Natural 28e Place Injury - At home, farm, street, factory, office building, etc. (Specify) investigation 1 TYes 2 Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tingle (Check only data and place, and due to the c 29d. Date signed (Month. Day, Year) 29c. License number O.C.M.E. May 25, 2004 d cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Locals JUN 0 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 6:25 a M **Physician** John Calvert Bush JUNE 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lorien Nursing Rehab. Center Columbia Howard 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 10 M 2 ☐ F 5. Social Security Number **Funeral** Months 78 MAY 10. 1926 Marvland Director 220-18-8556 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State or 28a-f show the Medical Examiner must be notified at 1 Yes 2 XNo **Funeral Director** Maryland Ellicott City Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21043 Itama 23a 2927 Normandy Drive USA 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No filed within 72 hours after 1 Never Married 2 Married ŏ 1 ☐ Yes 2 🕅 No Baltimore, Maryland 21215-0036 White Specify: If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "ns eny injury or other traumatic event, the Madic once. Elementary/Secondary (0-12) College (1-4or 5+) Model Shop Westinghouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Madeline Nolker Thomas L. Bush 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2927 Normandy Drive Ellicott City, MD 21043 Marion Adele Bush/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 6/7/04 Baltimore, MD ⁴ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funery Service Tubes MCC 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebrai VASCULAR **Physician** /Medical Due to (or as a consequence of) **Examiner** Trosclopho Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires thet the death certificate be executed Je muntra that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal dea 4 Pregnant at time of death 2 | Fetal death Year for Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: 26. Place of Death (Check only one) To Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: Natural Injury Division 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 | Homicide within 24 hours a filled To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of gentities lune, 07, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZKnoll WORTH DV. SAWM MD William 32. Registrar's Signature State Goode Registrar

		•	For State Registrar	State of Mar	•	ertificate o		nd Mental Hy	giene Reg. No. 2	004	18009
	Physicia /Medic		1. Decedent's Name (First, Middle, Last George Allan E					2. Date of De Month May 2	Day	Year	3. Time of Death
}	Examin	er	4a. Facility Name (If not institution, give	Drive		Chest	n, or Location of ertown ar If Under 2		Qu	eens An	
	Funeral Director		5. Social Security Number 218-01-3089 Usual Residence of Decedent	x 7. Age (i	n yrs. last birthday	Months Day		Min. 8. Date of Bir (Month, Da Mar 5,	1918	Country Maryl	e (State or Foreign) and
	Maryland a-f show filed at	tor	10a. State 10b. County	Anne's	Oc. City, Town or l Ches	ocation stertown				10d.	Inside City Limits 1 ☐ Yes 2X☐ No
	th with the 23a or 28i	Funeral Director	10e. Street and Number 157 Longfellow Dr	ive		10f. Zip Code 21 6	520		USA	What Country	
036	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28s-f show any injury or other traumatic svant, I'm Medical Examinar must be rectified at ADEs.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates:	9r in U.S. 13	. Was Decedent of If Yes, specify C		in? (Specify Yes or No , Puerto Rican, etc.)	BI	ace - American ack, White, etc. ify: White	
21215-0036	within 72 ho one. Ihen *netur ie Medical	Completed	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12)	cation de completed) College (1-4or 5+)	(Giv	edent's Usual Occ re kind of work do. DO NOT use ret	ne during most ired)	of working		Business/Indus	
Maryland 2	uld be filed valued by the filed valued Hygierked other file svant, it	To Be Co	17. Father's Name (First, Middle, Last) Walter Franklin E	Bullock	1	Cruck	18. Mother	r's Name <i>(First, Middl</i> e th Helen Wa	, Maiden Suma		.1011
	and 2 shousalth and N n 27 is maner trauma		19a. Informant's Name/Relationship (7) Margaret J. Smith		113	3 Centre	ville R	oad Queens	town, M	D 21658	
Baltimore,	. Peges 1 tment of He tent: If Iter jury or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 ☑ Donation 5 □ Other (Specify	1		ematory or other p	olace)	Date	20c. Location	ı - City or Town	, State
Bal	permil Depar Impor any in		21. Signal and Funerally Typice Licent ROD 21. Signal and Signal Roll 23. Party. Enter the disease or comp	Mul	tor S B	altimore	tomy Bo MD 2	oard 655 W. 1201			pproximate terval Between
	Physician /Medical		shock or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. CA a	Stown (consequence of):	ich ē	liver	metust	-79	In Oi	terval Between nset and Death
8760,	Examine executed physicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):						
.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 l 4 Pregnant at tin 9 Unknown	Fetal death 3	☐Ectopic pregna ☐ Other (specify,				ate of delivery donth Da	ıy Year
<u>α</u>	wrequires that been signed b should be deta	by	Part II. Other significant conditions of	entributing to death but	not resulting in the	Inderlying cause	given in Part I.		obacco use co Yes 2 No	ntribute to the d	cause of death?
Vital Records,	The law requirate has been page 2 should	Completed						24a. Was auto perfo 1 \(\text{Yes}	psy ormed?	prior to compli death?	findings available letion of cause of
of	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ion: To Be	27. Manner of Dath Natural 5 Pending	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Y		of 28c. Ir	Other				
Division	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		r - At home, farm, s (Specify)				Street and Nun wn, State)	nber or Rural R	oute Number,
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	edicai	(Check only 2 / Medicel Examone)	ysician: To the best of niner: On the basis of ex and manner state	xamination and/or	investigation, in m	ny opinion, deat	d place, and due to the hoccurred at the time,	date and place	, and due to the	e cause(s)
	with To I	M	29b. Signature and title of certifier		W (100 - 00) T	DI	6 4 8	38	5	ed (Month, Day	f. (1941)
	Sta	ite	30. Name and address of person who all the state of the s	redian	th (Item 23a) (Type s Signature	(*	hes t	entown	M	Å	
	Regist		JUN 0 8 2004	Denegan	D A	orkal					

			1 - For Stata Registrar	State of	Maryland			t of H	ealth a		lental Hy	giene _	004	18010
ı	Physic	ian	Decedent's Name (First, Middle,								2. Date of De.		Year	3. Time of Death
	/Medi		Viola D. Bri								JU		2004	11:58AM
	Exami	ner	4a. Facility Name (If not institution, Saint Joseph			- 60 50	4b. City,	Town, or	Location o			4c. Cour	ty of Death	
	- Francisco				Age (In yrs. Ia		If Under	1 Vear	If Under:	0 W S (imore
	Funeral Director		220-22-8445	1□M 2∏F	82	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da Dec 23	n y, Year) 1921	9. Birthp	lace (State or Foreign try)
	ס		Usual Residence of Decedent								DEC 25	, 1921	Mar	yland
	anylar show	_	MD 10b. County	.11		Town or Lo							10	0d. Inside City Limits
	8a-f	ecto	Julia	, <u> </u>		Vestmi	ister							1 ☐ Yes 2X No
	with t	Ē	10e. Street and Number				10f. Zip	Code				10g. Citizen o	f What Coun	try?
	eath	era	2 Atheny Court	12. Was Decede	nt Ever in II S	12 1	Vac Dassel		158		7.14		SA	
(0	ritan ritan	Funeral Director	1 ☐ Never Married 2 ☐ Marrie	Armed Force	s?	i. 15. V	Yes, spec	fy Cubar	n, Mexican	, Puerto	cify Yes or No- Rican, etc.)	14. Ha	ace - America ack, White, e	an Indian, etc.
8	72 hours after death with the Maryland Insturat, or items 23a or 28a-f show itea! Examirer must be notified at	by	3 M Widowed 4 ☐ Divorced	If Yes, Give Year or Date		1	☐ Yes 2	No No	Specify:			Spec	ify:white	e
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Maryland 21215-0036		_	19a. Informant's Name/Relationship	o (Type, Print)		19b. Mailin	g Address	(Street a			I Route Numbe	r City or Town	State Zin	Code)
	is 1 and 2 of Health a itam 27 ig other trav		Sherman Bristow	/son							thervil			
ore			20a. Method of Disposition			ice of Dispos metery, crem	ition (Nam	e of			ate	20c. Location		
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Baltimore,	permit. Page Department of Important: # any injury or once.		21. Signatur of Euneral Service Lie	Wade,	r dexigr	St	Name and ate A	Address nato	of Facility	pard	655 W.	Baltin	nore S	treet1201
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8	Examiner	_	Sequentially list conditions.	D. —	RY TR		NFEC	CTIO	N					
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	e dea he att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of dea		ctopic pre Other (spe					Mo	onth D	ay Year
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ŝ	ires the signe	þ	Part II. Other significant conditions	s contributing to death	but not resulti	ing in the und	derlying car	use given	in Part I,					cause of death?
Ö	requ been should	etec	LACTIC ACIDOSIS								1 🗆 Ye	s 2 No	3 Probab	oly 4 Unknown
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₹	Physician: this certificatal director, I	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	*ia-t 0 🗆 🗆	2/0		04			(Check only on			•
o	g Phy erthi		27. Manner of Death	28a. Date of In	jury 2	NOutpatient 8b. Time of		c. Injury a Work?	4 🔲 Nurs		e 5 Reside			
jo	Attanding r death. actor: After by the funer	Certification:	1 Matural 5 ☐ Pending 2 ☐ Accident investigati	(Month, E	ay Year)	Injury	М		s 2 🗆 No			,,		
<u> </u>	r Atta er de racto by th	tific	3 ☐ Suicide 6 ☐ Could not determine	d 286. Place of I	njury - At home	e, farm, stree	t, factory,	office		28	Sf. Location (Str	eet and Numb	er or Rural F	Route Number,
	ital or A irs after ral Dira led in by	Cer		Donaing,	Sto. (Opocny)						City or Town	, Stare)		
	To the Hospital or Attanding Physician: The law within 24 Hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier ← Certifying F (Check only one) ← 2 Medical Exp	Physician: To the bes aminer: On the basis and manners	or examination	edge, death on and/or inve	occurred at stigation, in	the time, my opin	date and ion, death	place, ar	d due to the ca	use(s) and ma te and place,	anner as state and due to th	ed. ne cause(s)
	To tha within 2 To tha complet	-	29b. Signature and title of certifier	1	\bigcirc 1	W	29c. l	icense n	umber			d. Date signe	1	y, Year)
			Sidnard	- Luit	Ticky		D	316	326		(0-3	-01	
			30. Name and address of person who	o completed cause of	death (Item 23	3a) (Type, Pr	int)							
	Sto.	0	RTCHARD I I	NTHICLIM 32 Perio	trar's Signatur		OSLE	R DI	RIVE	TOL	JSON M	arylar	W 21:	2014
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ORIGINAL

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		Physici		Decedent's Name (First, Middle STI	JART			BOOSE		2. Date of De Month	Day	Year	3. Time of Death
		/Medio Examin		4a. Facility Name (If not institution		per)			or Location of Death	JUNE	2, 20 4c. County		8:55A. "
14	3			13316 SHIPWRIGHT	CIRCLE			SOLOMON	NS		CALVE	RT	
3775		Funeral Director		5. Social Security Number 199–40–6310	6. Sex 7.	Age (In yrs. 47		Months Days		8. Date of Birl	, 1956	9. Birthpl: Count	ace (State or Foreign try) PA
		land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	/, Town or L	ocation				10	Od. Inside City Limits
		Marylan I-f show Iied af	to	MD CAL	VERT		SOLO	MONS					1 ☐ Yes 2 ☐ No
		death with the Maryland ms 23a or 28a-f show frrust Le notified at	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V	/hat Count	
		ath wi		13316 SHIPWRIGH	IT CIRCLE				20688			U	.S.A.
		er de:	Funeral	11. Marital Status	12. Was Decede	es?	S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race Blac	e - America k, White, e	
	36	Ir, or	by F	1 X Never Married 2 Marr 3 Widowed 4 Divorced	ied 1 □ Yes 2 If Yes, Give Year or Date			1 ☐ Yes 2 🔀 No	Specify:		Specify	: 1	WHITE
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	21	ithin 7	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4	lor 5+)	life.	DO NOT use retire		ing			
	12	led willygien her th		47. 5. 11. 12. 14. 14. 15. 16. 16. 16. 16. 16. 16. 16. 16. 16. 16	5+		ELEC	TRICAL EN	1				AR CENTER
	Maryland 21215-0036	d 2 should be filed within 72 hours after death with the Maryla In and Mental Hygtene. 7 Is marked other than "natural", or items 23a or 28a-1 sho traumatic event. It a Modeal Examinational tennellised at	To Be	17. Father's Name (First, Middle, HERBERT	Last)		B00	OSE	18. Mother's Name	e (First, Middle,	Maiden Sumam	-/	NSTEIN
	Mar	12 sh h and rism raum	l W	19a. Informant's Name/Relations					t and Number or Run				
	e)	permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 is any injury or other trau		BARBARA BOOSE /	SISIER	20b. P	lace of Dispo	osition (Name of	HIGHWAY,_#	402 - M	APLE SHA 20c. Location -		
	<u>o</u>	ages ant of nt: If it		1 ABurial 2 □ Cremation 4 □ Donation 5 □ Other (S)		ate C	emetery, cre	matory or other pla RE CEMETE	. 1	2004	JENKINT		
	Baltimore,	mit. F partm sorter / injur		21. Signature of Funeral Service		11011			ess of Facility SOL				
	ä	P P P P P P P P P P P P P P P P P P P		Koloto)	- Tun		> 89	900 REIST	ERSTOWN R	OAD - P	IKESVILI	E, MI	D 21208
				23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	ised the death	. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition resulting in death)	a Carbon	Monox	ide Iı	ntoxicati	on				Onset and Death
	b	/Medical Examiner		resulting in death)	Due to (or	as a consequ	ience of):						
		*	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or	as a consequ	ience of):					-	
		be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C.								
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	Вох	death atten	cian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth	h 2 ☐ Fetal	death 3[Ectopic pregnancy Other (specify)	у		23d. Date Mon	of deliver	y Day Year
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	S, T	res that igned to be det	by P	Part II. Other significant condition	ns contributing to deat	th but not resu	lting in the u	nderlying cause gru	ven in Part I.	23e. Did to	bacco use contri	bute to the	cause of death?
	ord	w require								1 🗆 Y	es 2 No	3 Proba	bly 4 🔀 nknown
	Records,	has be	Completed					<u></u>		24a. Was a autop	an 24b. W	ere autops	sy findings available pletion of cause of
										perfor 1X Yes	med? de 2□No 10	eath? Yes 2	?□ No
3	Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Death				- 1211 - 212 - 215
senden	o	Phys er this eral di	1: To	1. Yes 2 ☐ No 27. Manner of Death	1 Linps	atient 2 □ E Injury	28b. Time o	f 28c. Injur	ner: 4 ☐ Nursing Ho	me 5 ☐ Resid 28d. Describe h	ence 5X Othe ow injury occurre	r (Specify) d	SCHNE
Je Je	<u>o</u>	death. ctor: After y the funer	atlor	1 □ Natural 5 □ Pending 2 □ Accident investig		Day Year)	Found						ıst Fumes
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B 3		spital or A ours after neral Dirac filled in by			Residen	ce			C	ircle, S	Solomons	, Md	
1/2		To the Hospital or Attanding Physician: within 24 hours atter death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical	29a. Certifier (Check only one) 1 Certifying Medical E	g Physician: To the be Ex eminer: On the basis and m anner	s of examinat	vledge, deatl ion and/or in	h occurred at the tirvestigation, in my o	me, date and place, a opinion, death occurr	and due to the d ed at the time, o	ause(s) and mar late and place, a	ner as stat	ted. he cause(s)
(i)		To th withir To th comp	Me	29b. Signature and title of certifier	<			29c. Licens	se number	2	9d. Date signed	(Month, Da	ay, Year)
				· mest				0.0	C.M.E.		JUNE 3,2	004	
		0		30. Name and address of person w	who completed cause of	of death (Item	23a) (Type,	Print)	Street, 1				21201
		Sta Registr	2.1	31. Date filed (Month, Day, Year) JUN 0 8 2004	Se 32. Regi	istrar's Signat	ure Sp	als			······································	±ai XI	212VI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JUNE George Emerson Crandall 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HAVRE HARFORD CHESAPEAKE DE GRACE DRIVE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1**X**M 2□ F Days Yrs. Director 579-18-7923 81 09/12/1922 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director MD Harford TX Yes 2 □ No Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With Items 23a or 720 Chesapeake Drive USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 □ No If Yes, Give 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ğ 3

Widowed 4 □ Divorced Specify: Year or Dates: WW2 White "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na eny injury or other traumatic event, Ite M. dic. 2006. Elementary/Secondary (0-12) College (1-4or 5+) 11th Self-Employed Carpenter 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) William Cassius Crandall Florence May Shegogue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Yachera- Daughter 2612 Cedarhurst Dr., Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co. 06/04/04 West Chester, PA Signature of Funeral Service Licensee Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ui as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No 1 ☐ Yes 2 No 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ★ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After thi 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 726AM 1 Natural JUNE 3 2004 s after death SELF 2 Accident INFLICTED 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours are To the Funerel Dir 720 CHESAPEAKE HOME DRIVE HAURE DE GRACE, 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier ca the and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registra

State

30. Name and address of person glo completed cause of death (item 23a) (Type, Print)

JUN 0 8 2004

31. Date filed (Month, Day, Year)

UKNA, MD, DME

32. Registrar's Signature

DO014206

JUNE 4, 2004

HOLABIRD AUF BALTO, Md 21222

			1 - For State Registrar	State of Maryla		irtment of H		Mental H	ygiene	Z 11 11	4 18	NIL
4	Physic /Medi		1. Decedent's Name (First, Middle, Las FRANKLI	NR.C	Rous	·6			Peath Da	y Ye 4,20	ar Ø4 1:1	of Death
1	Exami	ner	4a. Facility Name (If not institution, give Saint Joseph 5. Social Security Number 6. S	Medical Cen	ter	If Under 1 Year	T C W S	O Ti	irth		ltimor	
	Director		Usual Residence of Decedent 10a. State 10b. County	M 2□F	92 Yrs.	Months Days	Hours Min	(Month, D	Day, Year)	3 1	Birthplace (State Country)	HUD
	the Maryis r 28a-f sho notified a	Director	MA Da .	more			nium		10g Cit	izen of What		es 2 No
9	iges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If itam 27 is markad other than "natural", or Items 23a or 28a-f show or other traumatic evant, the Modical Examinational by notified at	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 17 No		Vas Decedent of H		Specify Yes or N to Rican, etc.)		14. Race - A	Merican Indian, White, etc.	
21215-0036	"natural", o	Completed by	3 Widowed 4 □ Divorced 15. Decedent's Ed (Specify only highest gra	If Yes, Give Year or Dates: ucation de completed)	16a. Deced	ent's Usual Occup	during most of wo	rking	16b. K	Specify: L	white ass/Industry	
	ould be filed within Mental Hygiene. arkad other than atic evant, It e Matic evant,	Be Comp	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Whol.	esales	upplie	The (First, Middle	Ha B, Maiden	Ling Sumama	+ Air (and.
Maryland	12 should b h and Ment 7 is markac traumatic e	70	19a. Informant's Name/Relationship (7	YOUSE		Address (Street	1	12.1				
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Baltin	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licent	LUP	105 FOR 22.	PAIC HAPI Name and Address WEFUL A	EL - G ss of Facility 23 CTERNA	25 YORK	10,	Timon	num m	Or
1	Physician		23a. Part1. Enter the disease or compshock, or heart failure. List only of Immediate Cause (Final disease or condition could be received in death).	lications that caused the dea he cause on each line. a. FNEUMONIA	th. Do not ente	r the mode of dyin	g, such as cardiad	or respiratory a	arrest,	10000	Approxima Interval Be Onset and	ate etween
	/Medical Examiner	Examiner	resulting in death) Sequentially list non-fillone, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consect b	E HEAR	T FAILL	JRE					
8760,	cate be executed physician and the burial-transit	dicai Exar	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):							
P.O. Box 68	The law requires that the death certificate be executed tee has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1	al death 3 □E	Ectopic pregnancy Other (specify)			2	23d. Date of o	delivery Day	Year
Records, P	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death but not res	sulting in the und	derlying cause give	en in Part I.		tobacco u Yes 2[_	to the cause of	death? Unknown
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Vital		o Be	25. Was case referred to medical examiner? 1 Yes 2 XNo	Hospital: 1 KInpatient 2	EB/Outpatrant	20 DOA Othe	26. Place of Dea					
ion of	ing After une	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	at Nursing H	ome 5 Resi			oecify)	
	Die Die	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ý) 		1	City or To	wn, State)		Rural Route Nun	nber,
	e Hospital 24 hours a B Funaral I etely filled	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death out on and/or inve	occurred at the time stigation, in my op	e, date and place, inion, death occur	and due to the red at the time,	cause(s) date and	and manner and di	as stated. ue to the cause(s	s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	melta m	1.0	29c. License	number			4176	nth, Day, Year)	
	6		30. Name and addr of person who co				410		June	4 th,	२००५.	
	Sta	te	JOGINDER P MEH	A 32. Registrar's SigNa	1 OSLE		TOWSON	MARYL	AND	2120	4	
	Registr	100	11IN 0 8 2004	housen 19	Span	KN						

			Please	Type or Print in E			-	_	
			For State	State of Marylan	d / Department of		ental Hygi		IOOIE
			Registrar		Certificate of			1. No. 2004	10012
	Physicia /Medic		1. Decedent's Name (First, Middle, Las Alice E.	Ciesio	lka		2. Date of Death Month	Day Year 2, 2004	3. Time of Death 3. OO A-M
	Examin	_	4a. Facility Name (If not institution, give Sligo Creek No.	street and number)	Ctra 4b. City, Town,	or Location of Death	rk	4c. County of Death	comery Co.
	Funeral Director		5, Social Security Number 6. S. 214-38-1264 1	9x		r If Under 24 Hrs. s Hours Min.	8. Date of Birth Month, Day,		plece (State or Foreign ntry)
	yland		Usual Residence of Decedent 10a. State 10b. County	/ :	y, Town or Location				10d. Inside City Limits
	the Mai	Funeral Director	Mary land Prince	,	10f. Zip Code		10	g. Citizen of What Cou	1 ☐ Yes 2 🕅 No
	eath with	eral D	8300 26 th Pl	ace 12. Was Decedent Ever in U.		0783 Hispanic Origin? (Spec	ofv Yes or No-	14. Race - Ameri	A ,
5-0036	ours after d	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates:	If Yes, specify Cu	Hispanic Origin? (Speciban, Mexican, Puerto Ro o <i>Specity:</i>	lican, etc.)	Specify: White	ite
21215-0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination finial be notified at ance.	To Be Completed	15. Decedent's Ec (Specify only highest gra		16a. Decedent's Usual Occ (Give kind of work don life. DO NOT use retir	e during most of workin	g 1º	Sb. Kind of Business/Ir	ndustry Om C
Maryland 2	should be filed with nd Mental Hygiene marked other the umatic event, the	To Be Co	17. Father's Name (First, Middle, Last)	emeyer		18. Mother's Name Mary	(First, Middle, M. Alice	Edele	Pa
	1 and 2 sho Health and I em 27 le ma ther trauma		19a. Informant's Name/Relationship (O CONNOC, JE	19b. Mailing Address (Street, 205 E. J	of and Number of Ryral	Route Number.	City or Town, State, Zi	10.1
altimore,	Pages 1 and nent of He int: If item		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	Place of Disposition (Name of temetery, crematory or other place)		2004 L	Salfimole	own, State Maryland
Balti	permit. Pag Department Important: any injury c		21. Signature of Funeral Service Light	-14	22 Name and Add	ress of Facility Afternat	gves Fu	negal+Cre	8. 21093
	Disconining		23a. Parl 1. Inter the disease, or come shock or heart failure. List only immediate Cause (Final	of cause on each line.			respiratory arres	t,	Approximate Interval Between Onset and Death
}	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a conseq	uence of):	1			month
	sit sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq		ZHEIMER	s Typ	E	years
,092	te be executed ysician and e burial-transit	cal Examiner	that inflated events resulting in death) Last	c	uence of):				
68	tificat ng phy as th	fedi	15.55.111.5						
O. Box	Attending Physician: The law requires that the death certificate refath. ector: After this certificate has been signed by the attending physby the funeral director, page 2 should be detached for use as the	by Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	23c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of degree Unknown	il death 3 ⊟Ectopic pregnar			23d. Date of delive Month	ery Day Year
ds, P.O.	uires that the signed by do be detac		Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlying cause of	given in Part I.		cco use contribute to	
COL	w requir been si should	lete					24a. Was an	24b. Were aut	opsy findings available
al Re	t: The lavicate has	Completed						prior to co death? No 1 ☐ Yes	empletion of cause of
Ħ	siciar certif recto	Be c	25. Was case referred to medical examiner?	Hospital:	150/0.4-4-4-4 257 004	26. Place of Death			-
n of	ing Phys After this uneral di	on; To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time of linjury W	jury at 2	8d. Describe how	ce 6 Dother (Speci injury occurred	ry)
Division of Vital Records,	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	8 280 Place of Injury . At h	ome, farm, street, factory, offic	□Yes 2□No e 2	8f. Location (Stre City or Town,	et and Number or Rui State)	al Route Number,
_	e Hospital 24 hours e Funeral etely filled	edical Co		nysician: To the best of my kno miner: On the basis of examina and manner stated.	ation and/or investigation in my	coninion death occurre	d at the time dat	and place, and due !	o the cause(s)
	ro th within ro th compl	Me	29b. Signature and title of certifier	2 - 100	29c. Lice	nse number	29	d. Date signed (Month,	Day, Year)
)	0,15		► M- Fr	ray	1	D-17876	f	6-04-04	1
	_		30. Name and address of person who	completed cause of death (Item	m 23a) (Type, Print) 38 AVI5	COTTAGE	CITY	MD 207	22
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sign	de ports				

DHMH 17 Rev 1/2001

ORIGINAL

		1 - For State Registrar	State of Mar		epartme Certifica			and Me	ental H	lygie Reg.	20	n.	1901
Physic /Medi		Decedent's Name (First, Middle, L Irving	ast) Stanle	ey C	arney				2. Date of Month May	Death	Day 2004	Year	3. Time of Death
Examir		4a. Facility Name (If not institution, g. 1200 Darley	Avenue			Balt	Location o	e			4c. County	of Death	
Funeral Director		5. Social Security Number 6. 215–58–2230 Usual Residence of Decedent	Sex 7. Age (/ 1)X M 2 ☐ F 52	n yrs. last birtho Yr	Month	er 1 Year Days	If Under a	Min.	8. Date of (Month, 8-2-	Day, Ye	ear)	9. Birthp Cour V	
h the Maryland r 28a-f show . notified at	Director	Md Ni 10a. State 10b. County Md Ni 10a. Street and Number		Oc. City, Town o	altimo	re lip Code				10g.	Citizen of		0d. Inside City Limits 1 XYes 2 ☐ No
be filed within 72 hours after death with the Maryland tall Hygiene. Id other than "natural", or items 23s or 28s-f show avant, the Modical Examire must be notified at	by Funeral	1200 Darley Ave 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No IXYes, Give Year or Dates:	r in U.S.		ecify Cuba		gin? (Spec , Puerto R	ify Yes or ican, etc.)	No-		ce - Americ ck, White,	etc.
d 2 should be filed within 72 hours aft this and Montal Hygiens 77 is marked other than "natural; or traumatic avant, Ire Modest Exami	Completed	15. Decedent's to (Specify only highest green tary/Secondary (0-12) 11th grade 17. Father's Name (First, Middle, Las	College (1-4or 5+)	(C	ecedent's Us Bive kind of w fe. DO NOT Labore	rork done d use retired,	luring most)				Vari	les	dustry
should be find Mental It is marked of umatic avail	To Be	Irving	Stanley		y, Sr.		<u>.</u>	Shirle	ey	Ŋ	den Suman 1ae	R	pyster
l ar lea her		19a. Informant's Name/Relationship Dante¹ Blowe 20a. Method of Disposition 1☆ Burial 2 □ Cremation 3	Brother	26 20b. Place of D	lailing Address 69 Edn sposition (Nacrematory or	ondsc	n Ave		altim	ore.		212	23
permit. Pages 1 ar Department of Hea Important: If item: any injury or other		4 Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice		Garris	22. Name a	ind Addres		B	altim	ore		2120	s, Md. D2
/Medical Examiner busings and busings and the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	,	e ()	the	sele	nti	Cen	dò	sih	Orse	Onset and Death
the death certifi y the attending iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	3 □Ectopic p 5 □ Other (s						23d. Dat Mor	e of deliver	y Day Year
The law requires that ate has been signed b	by	Part II. Other significant conditions	contributing to death but no	ot resulting in th	e underlying	cause give	n in Part I.				_	ibute to the	a cause of death?
	e Completed	25. Was case referred to medical					OC Plans	of Dooth	1 Yes	opsy formed? 2 🗆 f	?	rior to com eath?	sy findings available pletion of cause of ☑ No
ding Phys h. After this funeral dii	atlon; To B	examiner? 1	28a. Date of Injury (Month, Day Ye	2 ER/Outpa 28b. Time Injur	e of	OA Other	at	sing Home	5 Res	sidence	6 XIOthe jury occurre		Scene
Dirte	Certification;	3 Suicide 6 Could not to determined		At home, farm, pecify)	street, factor	y, office		281	f. Location City or To	(Street own, Sta	and Numbe ate)	er or Rural	Route Number,
To the Hospital or At within 24 hours after of To the Funeral Diract completely filled in by	edical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exec	hysicien: To the best of m miner: On the basis of exa and manner stated.	y knowledge, de mination and/or	eath occurred investigation	at the time n, in my opi	e, date and nion, death	place, and occurred	d due to the at the time	e cause , date a	(s) and mar and place, a	ner as sta nd due to	ted. the cause(s)
Within Some	Σ	29b. Signature and title of certifier The flux 1 30. Name and address of person who	1. Kit ~	2			ME			Jı	oate signed	200	
. 9)													_

			ricasa	State of Mar				nd Mental Hyg		
		•	1 - For State Registrar	State of Ivial			e of Death		leg. No. 200	4 18017
- 7	Da #	4	Decedent's Name (First, Middle, L.	ast)	111		_	2. Date of Dea	th Dayrol Year	3. Time of Death
1	Physici /Medic	al .	MARGA	KET	OLIE	, ,		JUNE	6 20	047:151
	Examin		4a. Facility Name (If not institution, g		Io an i tal		Town, or Location of	Death	4c. County of Dea	ath 4
372		2 9	Howard Coun 5. Social Security Number 6.		(In yrs. last birthday)	If Under			Howard 9. Bi	irthplace (State or Foreign Country)
	Funeral Director		217-01-0297	1□M 2፟ØF	86 yrs.	Months	Days Hours	June 2	6, 1917 Ma	aryland
	pu »		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or L	ocation				10d. Inside City Limits
	laryla shov	ō	Md. Carro		Finks					1 ☐ Yes 2X No
	28a-	Director	10e. Street and Number			10f. Zip	Code		10g. Citizen of What C	Country?
	th with		2551 Balto. 1	Blvd. #77			048			5.A.
	r dea	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Deced If Yes, spec	tent of Hispanic Origi ofly Cuban, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Am Black, Wh	
36	iurs after death with the Marylan el', or itema 23e or 28e-f show Examiner must be notified at	by Fi	1 ☐ Never Married 2 ② Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes	No Specify:		Specity: Wh	ite
21215-0036		ted	15. Decedent's (Specify only highest of	Education	16a. Dece	edent's Usua	al Occupation	of working	16b. Kind of Busines	s/Industry
215	€ 64	Completed	Elementary/Secondary (0-12)	College (1-4or 5+		DO NOT US Secre	rk done during most of se retired)		Balto. Ci	tv Police
121	filed with Hygiene Ather the		17. Father's Name (First, Middle, La	st)		50010		s Name (First, Middle,		
au	d a b	To Be	Victor E.				Ed	dna M. Cros	S	
Maryland	should and Menis marke	-	19a. Informant's Name/Relationship			-		or Rural Route Numbe		
	s 1 and 2 f Health item 27 i		Samuel J. Colle	ett - Husban				#77 Finksb	urg, Md. 2	
lore	S == 0		20a. Method of Disposition 1 Derial 2 Cremation 3		20b. Place of Disp cemetery, cre	matory or o	(fardens	June 9, 20	•	
Baltimore,	permit Page Department o Important: If any in ury or once.		* 4 □ Donation 5 □ Other (Spe 21. Signature of F n 11) ervice Lice		3					
Ba	permit Departm Imports any in u		14/5	Concett		1160	arat runer 5 Reisters	stown Rd.,	P.A. Owings Mil	ls, Md. 21117
₫.	4	П	23a. Pak1. Enter the disease, or co shock, or heart failure. List or	emplications that caused to	the death. Do not er	iter the mod	le of dying, such as c	ardiac or respiratory ar	rest,	Approximate Interval Between
4	Pnysician		Immediate Cause (Final disease or condition	SEP	TIC S	SHe	CK		2	Onset and Death
8	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	FD	515			AGOV 14
		ē	Sequentially list conditions,	b. Due to (pr as a	consequence of:					The state of the s
	uted	Examiner	Sequentially list conditions, if any, leading to innediate cause. Enter Underlying Cause (Disease or injury that initiated events	PNE	UMON	SIA	_			V 33
,0	e be executed sician and e burial-transit		resulting in death) Last	Due to (or as a	consequence of):	~ 15	= hyer	ARDY AL	LIFERE	700
09289	cate b	dical		d. 1400	7	500	, , , , , ,	MACME	MILI	
	leath certificate b attending physical of the later as the base and the base and the base and the base the base the base the base the base and the b	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of d	elivery
. Box	death e atte	icia	in the past 12 menths? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown		□Ectopic p □ Other (sp			Month	Day Year
P.0	that the death ed by the atte detached for	Phys	9 Unknown		t not reculting in the	underhing c	nouse groon in Part I	23e Did to	shacco use contribute	to the cause of death?
	8 6 9	Completed by Physician/Medi	Part II. Other significant condition	D STACE		NAL	JUET.	SE 101		Probably 4 Unknown
cor	w requir been si should	letec	DEUFNITO	Δ_				24a. Was	an 24b. Were	autopsy findings available
of Vital Records,	hysician: The law his certificate has b I director, page 2 s	dmo	STROKE						rmed? prior to death?	
ital	ian: artifica ctor, p	BeC	25. Was case referred to medical examiner?					of Death (Check only o		
of V	Physician: this certific ral director,	2	1 Yes 2 No	Hospital: Inpatier			OA Other: 4 Nur 28c. Injury at	sing Home 5 Resid	dence 6 Other (Sp	pecify)
on (ding F h. After funer	tion	27. Manner of Death 1		Year) Injury		Work? 1 ☐ Yes 2 ☐ N		iow injury occurred	
Division	Attanding ir death. ector: Alter by the fune	Certification;	3 Suicide 6 Could no 4 Homicide determin	ot be Geo Place of Injur	ry - At home, farm, s	treet, factor	y, office	28f. Location (S City or Tox	Street and Number or i	Rural Route Number,
Ō	tal or rs afte el Dir	Cert	4 I Hamedo	building, old	. (Ороспу)					
	To the Hospital or Attanding Physic within 24 hours after death. To the Funerel Director: After this of completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best o xaminer: On the basis of and manner stat	examination and/or i	ath occurred investigation	at the time, date and n, in my opinion, deat	d place, and due to the h occurred at the time,	cause(s) and manner a date and place, and di	as stated. ue to the cause(s)
	othe ithin 2 outle	Mec	29b. Signature and title of certifier	1 112		29	c. License number		29d. Date signed (Mo	nth, Day, Year)
			> KNKO	24/100		D	5398	7	UNE, 7	IT ZOCKE
	4	0	30. Name and address of person w	no completed cause of de	eath (Item 23a) (Type	e, Print)	CENNET	H GEH	, MD	1 - 1
			31. Date filed (Month, Day, Year)	7 1018C	11 TE 3	9	BAUTU	WRE 1	10 21	20
	St Regist	ate trar	JUN 0 8 200	4 Jenes	P	Spa.	Cal			

			1 - For State Registrar	State of Mary			f Health an of Death		iene	n
	Physic	ian	1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month		Year 3. Time of Death
	/Medi	cal	Sarah J. C1 4a. Fecility Name (If not institution, give					June	4 20	004 9:15 A M
1	Exami	ner	1053 Elm Ro			4b. City, Tow	m, or Location of D Arbutus	eath	4c. County	
	Funeral		5. Social Security Number 6. Se	7. Age (In	yrs. last birthday)	If Under 1 Ye	ear If Under 24 I			altimore 9. Birthplace (State or Foreign
	Director		212-20-2543	□ M 2 XF 78	Yrs.	Months Da	iys Hours N	Jun. 27,	1925	9. Birthplace (State or Foreign Country) Maryland
	and and		Usuel Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	cation				104 1-14-05 11 3
	Marylan f show	ţ	MD Balt	imore	,,	Arbu	· +··· a			10d. Inside City Limits 1 ☐ Yes ※☐ No
	r 28a	Director	10e. Street and Number			10f. Zip Cod		1	0g. Citizen of W	
	th witi		1053 Elm Road			2	21227		United	
	r dea	Iner	11. Marital Status	12. Was Decedent Ever i	n U.S. 13.			(Specify Yes or No- erto Rican, etc.)	14. Race	e - American Indian, k, White, etc.
36	rs afte	y F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ∐ Yes 2 ሺ No If Yes, Give Year or Dates:	1	¹□Yes 2 X]≀		, , , , , , , , , , , , , , , , , , , ,	Specify	
21215-0036	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or Items 23s or 28s-f show event, the Medical Examinat must be recitified at	Completed by Funeral	15. Decedent's Ed	ucation	16a. Deced	ient's Usual Oc	cupation			
215	hin 7.	plet	(Specify only highest grad	de completed) College (1-4or 5+)	(Give	kind of work do DO NOT use re	ne during most of	working	16b. Kind of Bu	siness/industry
21	filed with Hygiene. other there	Com	12			Secr	etary		Bu	siness
and	be fit atal H d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's h	Name (First, Middle, A	faiden Sumame	э)
Maryland	2 should be and Mental is marked o	P	Michael Ingrilli 19a. Informant's Name/Relationship (7)	Deleta Deleta				cy Camma		
Ma	2 m m	r °		aughter				Rural Route Number,		State, Zip Code)
Baltimore,	s 1 and 2 f Health Item 27 other tra		20a. Method of Disposition	20	 b. Place of Dispos 	sition (Name of		Arbutus, M		City or Town, State
E O	permit. Pages of Popartment of Pluportant: If Ite any injury or ol once.	1	1 Burial 2 Cremation 3	Removal from State M	D vete ta		Ptery	3-2004		ville, MD
alti	permit. Departm Importa any inju	(21. Signature of Funeral Service Lane	lee /		TITE . Name and Add		mbrose Fun	eral Ho	me. Inc.
<u>m</u>	88288		TO THE PARTY	WALL MAN	13	28 SU1p	hur Spri	ng Rd., Arl	butus,	MD 21227
	Physician /Medical Examiner	Iner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of limediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Final Indenty	a. Due to (or as a control of the co	equence of):	for mass	luve	activity and	31,	Approximate Interval Between Onset and Death I months
Box 68760,	death certificate be executed e attending physician and d for use as the burial-transit	Physiclan/Medical Examiner	resulting in death) Last	Due to (or as a const. Due to (or as a const.) 23c. If yes, outcome of pre-1 Live birth 2 F	gnancy etal death 3	Ectopic pregnar	ncy			of delivery
0	the y th	hysic	1 Yes 2 No 9 Unknown	4 Pregnant at time of 9 Unknown		Other (specify)			Mont	h Day Year
Records,	The law requires that te has been signed b page 2 should be deta	by	Part II. Other significant conditions co	ntributing to death but not	resulting in the un	derlying cause (given in Part I.			oute to the cause of death?
		Completed						24a. Was an autopsy performe	ed? de	ere autopsy findings available or to completion of cause of ath? Yes 2 \textsquare No
Vital	s certi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	fospital: 1 Inpatient 2	Province in the second	- T 10)ab a -	eath (Check only one,		
0	g Phys er this eral di	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	☑ ER/Outpatient 28b. Time of	3□ DOA 28c. Inj	4 🗆 Nursing	Home 5 Residen		
jo	ttending I death. tor: After the funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year,	Injury		/ork? □Yes 2□No		, ,	
Division of	l or A after Direc I in by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - Al building, etc. (Spe	t home, farm, stre icify)	et, factory, office	9	28f. Location (Stre City or Town,	et and Number State)	or Rural Route Number,
	To the Hospital within 24 hours: To the Funeral completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Phy: 2 Medical Exami	sician: To the best of my kener: On the basis of examinand manner stated.	nowledge, death ination and/or inve	occurred at the estigation, in my	time, date and place opinion, death occ	ce, and due to the cau curred at the time, date	se(s) and manr e and place, an	ner as stated. d due to the cause(s)
	To the within 7 To the comple	×	29b. Signature and title of certifier	P.		1	nse number			Month, Day, Year)
}	3			uno	ny	5	D452-	74.	6/8	704
	6		30. Name and address of person who co	. 516 N	Rolling	rint) Roca	# 20	4, 6000	180,(10,	MD 21228.
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature J	Anne	A			

DHMH 17 Rev 1/2001

ORIGINAL

	_		1 - Stete Registrar AMEND ITEM #. 1. Decedent's Name (First, Middle, Last)	26 PER I	aryland / Depa PHY G832 Cel	tillicate of	Death	Re 2. Date of Death	g. No 200 L	18019
	Physici /Medi		Maria I. Cortes-Pe					Maynth 21,	2004 Year	0746 А м
	Examir	ner	4a. Facility Name (If not institution, give str Union Memorial Hos			4b. City, Town, o Balti	r Location of Dea MOTE	th	4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 □ N	7. Ag	ge (In yrs. last birthday) 9 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		year) , 1915 Puer	place (State or Foreign http:// cto-Rico
	Maryland -f show	tor	Usual Residence of Decedent 10a. State New York Usual Residence of Decedent 10b. County Queens		10c. City, Town or Lo				1	0d. Inside City Limits 1 Yes 2 □ No
	h with the 3a or 28a st be noti	al Direc	10e. Street and Number 12–21 35th Avenue		J	10f. Zip Code	106	10	g. Citizen of What Cour USA	ntry?
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If if Health and Mental Hygiene. If if them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at	Completed by Funeral Director	11. Marital Status 12 1 Never Married 2 Married 3 Myldowed 4 Divorced	Was Decedent Armed Forces? 1 Yes 2 H If Yes, Give Year or Dates:	No	Was Decedent of H f Yes, specify Cuba	_	Specify Yes or No- to Rican, etc.)	14 Race - Americ Black, White, Specific 12	
Maryland 21215-0036	I within 72 ho iene. r than "natur the Medical	ompleted	15. Decedent's Educal (Specify only highest grade of Elementary/Secondary (0-12)	ion ompleted) College (1-4or !	(Give life. L	dent's Usual Occup kind of work done o DO NOT use retired	during most of wo	rking	6b. Kind of Business/In	,
yland	ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last)	Uı	nknown			me (First, Middle, M	a <i>iden Sum</i> ame) Unkn	ıown
Mar	nd 2 sh ulth and 27 is m r traum		19a. Informant's Name/Relationship (<i>Type</i>) Isabel Torres	Print)				ural Route Number, City Nev	City or Town, State, Zip W York 111	
Baltimore,	permit. Pages 1 and 2: Department of Health at Important: if Item 27 is any Injury or other trait		20a. Method of Disposition 1X□Surial 2 □ Cremation 3 □ Ren 4 □ Donation / ∮ □ Other (Specify)	oval from State	St. Michael of Dispo	sition (Name of	1	Data o	oc. Location - City or To ast Elmhurs	own, State
Balti	Departing Department Importa any inju		21. Signature of Fureral Service Licensee	. We	Bu 36	Name and Address rgee-Hens	ss of Facility SS—Seitz Road B	Funeral laltimore,	Home, Inc.	21211
i	Trysician /Medical		23a. Part / Enter the disease, or complica shock, or head failure. List only one Immediate Cause (Final disease or condition resulting in death)	Acut	the death. Do not entendentelle.	er the mode of dyin	g, such as cardia	fanct	in,	Approximate Interval Between Onset and Death
	Examiner	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to for as	a consequence of): a consequence of):	ion				Bars
.O. Box 68	ne death certific the attending p thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
ords, P.	w requires that to been signed by should be detac	by	Part II. Other significant conditions contrib	outing to death b	ut not resulting in the un	iderlying cause give	en in Part I.		cco use contribute to th	e cause of death? ably 4 □Unknown
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ō	ing Pnysic	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hos 27. Manner of Death 1 Actival 5 Pending 2 Accident investigation	oital: 1 Inpatie 28a. Date of Inju (Month, Day		28c. Injury Work	4 🗆 Nursing H	ome -6 Effections 28d. Describe how)
Division	2 2 2 2	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ury - At home, farm, stre c. (Specify)	eet, factory, office		28f. Location (Stree City or Town,	et and Number or Rural State)	Route Number,
	to the hospital or within 24 hours afte To the Funeral Dir completely filled in I	edical	29a. Certifier (Check only one)	an: To the best of On the basis of and manner sta	examination and/or inv	occurred at the tim estigation, in my op	e, date and place inion, death occu	, and due to the caus rred at the time, date	se(s) and manner as sta e and place, and due to	ated. the cause(s)
	within 24	M	29b. Signature and title of certifier		00.	29c. License	number	9	Date signed (Month, G	ay, Year)
	le		30. Name and address of person who comp	leted cause of de	eath (Item 23a) (Type, F	Print)	Paroli	B 120	Dimon 11	D 21210
	. Sta Registr	•	31. Date filod (Month, Day, Year) JUN 0 8 2004	32. Registra	ar's Signature	book	· curs		1000 101	

			1 - For State Registrar	State of Ma		artment o		nd Mental Hyg	giene 1002001	1802	0
	Physici	an	Decedent's Name (First, Middle, Last					2. Date of Dea Month	Day Year	3. Time of Death	
	/Medic	al	Charles Ted (4a. Facility Name (If not institution, give			4h City Tow	n, or Location of [June 3	2004 4c. County of De	12:25 P	М
Н	Examin	er	16409 J.M. Pearce	•		40. Olly, 101	Monkton	Julia	1	imore	
	Funeral		5. Social Security Number 6. Se		(In yrs. last birthday)	If Under 1 Ye Months Da	ear If Under 24	Hrs. 8. Date of Birth Min. (Month, Day		irthplace (State or Foreign	gn
	Director		219-20-8546 Usual Residence of Decedent	M ZLIF	77 Yrs.		70 1100.0	May 25,	1927	Maryland	
	yland Now		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limit	ts
	e Mar	ctor	Md. Bali	imore		Monkto	on			1 ☐ Yes 2 🛣N	lo
	with th	Director	10e. Street and Number			10f. Zip Cod		1	0g. Citizen of What 0	Country?	
	leath v	Funeral	16409 J.M. Pearce	ROAD 12. Was Decedent E	ver in U.S. 13. V		21111	2 (Specify Ves or No-	USA 14. Race - Am	perican Indian	
9	after d		1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ No	0	_		? (Specify Yes or No- Puerto Rican, etc.)	Black, Wh		
9	72 hours after death with the Maryland natural', or items 23a or 28a-f show dical Examiner must be notified at	d by	3 X Widowed 4 ☐ Divorced		MMII	1 Yes 2			Specify:	White	
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	be filed tal Hygie d other event, II	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle, I	Maiden Sumame)		
Z Sa	should be nd Mental marked o	2	Elmer Cann	0-/1	401 14 111			elen Janne			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event, the Midical Examination at the molified at 90es.	1	19a. Informant's Name/Relationship (T) Mr. A. Doug Cann/So					ive Cockeys			
re,	of Heal		20a. Method of Disposition		20b. Place of Dispo-				20c. Location - City o		-
Baltimore,	Pages ment of I ant: If Its ury or o		1 ☐ Burial 2 🖾 Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Hilltop S	ervice	Corp. 6	/5/04	Towson, Ma	rvland	
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	Physician		23a. Part1. Enter the disease, or of hol shock, or heart failure. List only of Immediate Cause (Final							Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	Due to (or as a	consequence of):	ge c	T 200	votive l	ing	years	
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	nsit	Examiner	Cause (Disease or injury	Due to (or as a	consequence of:						
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Box	attene aftene I for us	Physician/Me	in the past 12 months?	3c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti	Fetal death 3	Ectopic pregna Other (specify)			23d. Date of de Month	livery Day Year	
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ord	w requir been si should	eted	avgesto	Hea	y Jan	lin	د		s 2 No 3 P	robably 4 Unknown	1
Record	Physician: The law r this certificate has b ral director, page 2 s	Completed						— 24a. Was ar autopsy perform	y prior to	utopsy findings available completion of cause of	0
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	nysiciu nis cer direct	To B	examiner?	ospital: 1 Inpatient	2 ER/Outpatient	3□ DOA	Other	Death (Check only one ng Home 5 Reside		cifv)	
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<u>></u>	al or A after I Direction by	Certification:	4 Homicide determined	building, etc.	y - At home, farm, stre (Specify)	et, ractory, ome	28	City or Town,	eet and Number or R , State)	urai Houte Number,	
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	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	01107	and manner state	id.			occurred at the time, da			
	7 × 5 8	_	29b. Signature and title of certifier		1		ense number	29	od. Date signed (Mont	n, vay, Year)	
	112	-	30. Name and address of person who co	mpleted cause of dea	ith (Kerf 23a) (Type, F	Print)	0 000	St. Bal	101000	~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician William J. Carty 1115 PM May 25 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Bel Bel Aw If Under 1 Year | If Under 24 Hrs. HEALTH Hartord Mariner Bel ತ್ 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 498-16-0013 1**∑**M 2□F 84 Yrs Director Sept 2, 1919 Missouri Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Harford Fallston 1 Yes 2 No Director 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 500 Millwood Drive 21047 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No þ Specify: White 3 Widowed 4 Divorced **'**37-39 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) millwright 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alphonso Carty Rosa Ijams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Carty/wife 500 Millwood Drive Fallstown, MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 □ Other (Specify) of Euneral 9 rvi 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street rans Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** hermer 1eavs /Medical as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) signed by the attending physician a d be detached for use as the burial-Physiclan/Medical as t IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 □Unknown 1 Tyes 2 JNO Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 Yes 2 No ector. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Medical Certification: To 2 🗆 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) W o completed cause of death (Item 23a) (Type, Print) ANYER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 0 8 2004

			1 - For State Registrar	State of Ma	ryland / Depa		lealth and N	lental Hy	•	4 18022
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Las LOUIS, CON 4a. Fecility Name (If not institution, give	STANT		4b. City, Town, or	Location of Death	2. Date of Dea Month OG/	Day Yea 4c. County of De	04 11/45 PM
	Funeral Director		5. Social Security Number 6. Sec	7. Age	(In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day March 4	h 9. E	Birthplece (Stete or Foreign Country) aryland
	r 28a-f ehow	Irector	10a. State 10b. County Md . N/A 10e. Street and Number		10c. City, Yown or Lo				10g. Citizen of What	10d. Inside City Limits 1 ☑ Yes 2 ☐ No Country?
336	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or items 23a or 28a-f ehow event, I'm Medical Exardinal must be notified at	Completed by Funeral Director	2816 Northern F 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Parkway 12. Was Decedent Ev Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		Z1 Was Decedent of Hid Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi Specify: Wh	
Maryland 21215-0036	filed within 72 hou Hygiene. other then "nature ent, the Mudical E	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	luring most of work)	ing	16b. Kind of Busines	
aryland		To Be (17. Father's Name (First, Middle, Last) James 19a. Informant's Name/Relationship (7)	Constantini Type, Print)		ng Address (Street a	Basiliki		Maiden Sumame) Grammatic r, City or Town, State	
ď	1 and 2 Health tem 27 other tr		Mr. James Constan 20a. Method of Disposition 1	Removal from State	20b. Place of Dispo	sition (Name of matory or other place	a)	Date	e, Md. 210 20c. Location - City of Cub Hill,	or Town, State
Balti	permit. Pages Department of Important: If It eny injury or o		21. Signature of Funk rul Service Licen 23a. Pert1. Enter the disease, or comp	\$0 9)	22	. Name and Addres	s of Facility	ral Home	e. Inc.	Approximate
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		Be Completed	25. Was case referred to medical examiner?				26. Place of Death		med? prior to death?	autopsy findings available completion of cause of
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Οį	To the Hospitel or A within 24 hours after to the Funerel Directompletely filled in by		4 Homicide determined 29a. Certifying Phy	building, etc.	mv knowledge, death	occurred at the tim	e date and place	City or Town	ause(s) and manner a	hateta au
ı	To the H within 24 To the Fi complete:	Medical	29b. Signature and title of certifier	iner: On the basis of early manner state	xamination and/or inv	29c. License	inion, death occurr	ed at the time, d	ate and place, and due of $\frac{1}{2}$	oth, Dey, Year)
	8 Sta	te ar	30. Name and address of person who of the second se	OMAS MI	0 600		IARITA		OS PIMA L.	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1:07 PM LLOYN CAPPENTER CHAPLES ,2004 JUNE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner UNIVERSITY OF MARYLAND HOSPITAL Baltimore N/A 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 219-38-0226 61 JUN 18. 1942 Director Maryland Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ms 23a or 28a-f show must be notified at 1∭Yes 2 □ No N/A Director Maryland Baltimore 5 4 1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 814 William Street 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status the Medical Examiner 1 Never Married 2 Married ö 1 ☐ Yes 2 No Specify: altimore, Maryland 21215-0036 White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manager Aero Space 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lester Carpenter Helen Farver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary G. Carpenter/wife 814 William Street Baltimore, MD 21230 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete permit. Page Department of finbortant: If eny injury or Metro Crematory, Inc. 6/4/04 Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungial Service Licensee C Mald ²² Name and Address of Facility Cremation Society of Maryland, 299 Frederick Road Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final PULMONARY **Physician** EMBOLIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CANCER LUNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐ Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 →Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy certificate 200 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 3 DOA Certification: To After th 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 SNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide To the Funeral 162 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number P16490 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MARYLAND 21201 ROBERICK Kreisberg 22 South Greene Street 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 8 2004 Registrar

		1	For State Registrar	State of M	arylan		rtment of H		and Me		jiene 20	04	18024
	al sist		1. Decedent's Name (First, Middle, L							2. Date of Dea Month	Day	Year	3. Time of Death
Е	Physicia /Medic	al .	ROBERT	CORE					4 Dansh	6/2/	4c. County	of Dooth	10:45 PM
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	Funeral			Sex 7. A		علالا (ast birthday	If Under 1 Year	If Under		8. Date of Birth (Month, Day	Veer	9. Birth	place (State or Foreign
	Director		213 80 9317	1 ☐ M 2 ☐ F	68	Yrs.	Months Days	Hours	Min.	11/11/	35		MD.
	pus *	l ⊢	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	Maryli f sho		MD na			BA	LTIMORE						1, Yes 2 No
	r 28e	rec	10e. Street and Number				10f. Zip Code			T.	10g. Citizen of V	Vhat Cou	ntry?
	th with	aiD	1121 ST AGN	ES LANE				21207			USA		
	tems	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces	?	S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Ori in, Mexican	gin? (Spec n, Puerto R	cify Yes or No- lican, etc.)	14. Rac	e - Amen k, White,	can Indian, etc.
36	irs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2X If Yes, Give Year or Dates:	NO		1 ☐ Yes X☐ No	Specify:			Specify	· BL	ACK
21215-0036	within 72 hours after deeth with the Maryland ene. Than "natural", or Items 23a or 28e-f show he dieal Exactiner must be notitied at	ted	15. Decedent's (Specify only highest of	Education		16a. Dece	dent's Usual Occupa	ation	t of workin	a	16b. Kind of Bu	usiness/In	dustry
2	ithin 7 ne.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retired	1)			FRUIT	CO	
	filed w Hygier other th		12 17. Father's Name (First, Middle, La	O St)		OIX	TITO MOIL		er's Name	(First, Middle,	Maiden Surnam		
Maryland	0	To Be		TAYLOR					EAI	RLENE	WASH	IING	TON
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	and 2 ealth m 27 i		EZELL TAYLOR	BROTHE			1 ST AGN sition (Name of	VES I		BALTO	20c. Location -		
ore	it of H it of H if ite or oth		20a. Method of Disposition 1 Burial Cremation 3	Removal from State	, 0	emetery, crei	natory or other plac				CATONS		
Baltimore,	nit. Pe artmer ortant injury		*4 □Donation *5 □Other (Special Signature of Suneral Service Lice		WII		CREMATOR Name and Addres	-	3/5/(by	J4	OIII OIIE	, , 111	LL, MD.
Ba	permit. Peges 1 and 2 should by Oppartment of Health and Menta Important: If item 27 is marked any injury or other traumatic en <u>once.</u>) Ceala	goting			ESTEP 1	BROS EUTAV	w FL	NERAL BALT	HOME I	$\frac{2 \cdot 4}{21}$	217
	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	aDue to (or a	ine.	the	er the mode of dyin	wt	cardiac or	dise	rest,		Approximate Interval Between Ons and Death
8760,	ate be executed whysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a d.									
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rds, P.	w requires that the is been signed by the should be detached	by	Part II. Dther significant condition	s contributing to death	but not res	ulting in the u	nderlying cause giv	en in Part I	i. 		obacco use cont ′es 2□No	nbute to	he cause of death?
I Record	The la ate has page 2	Completed								24a. Was autop perfor 1 Yes	med?	prior to co death?	opsy findings available impletion of cause of
Vital	Physicien: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	Hospital:		5BIO	Oth	05		Check on o		(С	4.1
of	ling After Tune	tion: To	1 Yes 2 No 27. Manner of Dearh Natural 5 Pending investiga	28a. Date of In (Month, D		28b. Time of Injury	f 28c. Injur Wor	-	2		lence 6 Doth		79)
Division	or Attending Pater death. I Director: After to in by the funera	Certification:	3 Suicide 6 Could no determin	t be 28e. Place of I	njury - At ho etc. <i>(Specif</i>	ome, farm, st	reet, factory, office		2	28f. Location (S City or Tow		er or Rur	al Route Number,
	To the Hospitel or within 24 hours aft To the Funerel Discompletely filled in	edical C		Physician: To the best taminer: On the basis and manner:	of examina								
)	To the within 2 To the complet	Me	29b. Signature and title of certifier	1	_ 1/2	Lanc	29c. Licens	e number	770	9	29d. Date signe	5/1	24
	7		30. Name and address of person	no completed cause of	death (her	m 23a) (Type,	Print) 5	((o 1	v. R	· (lin	Pd E	n/h	ad 24728
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			For State		State of Ma	aryland	d / Depa	irtment of F tificate of	Health and N	Mental Hy	giene 2	004	18025
			Registrar Decedent's Nam	ne (First, Middle, L				incate of	Dealii	2. Date of De	1109.110.		3. Time of Death
	Physici		Rosal	ene M. C	harles					Month MAY	30 Day 2	004	11:10 a ^M
	/Medio Examin		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, o	or Location of Death	1		nty of Death	11110 0
			St. Man	ry's Hos	pital			Leona	ardtown		St.	Mary	s
	Funeral		5. Social Security N		4 T 44 ATT 5		ast birthday)	If Under 1 Year Months Days		8. Date of Bi (Month, D.	rth av. Year)		lace (State or Foreign
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	and and		Usual Residence o	10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits
	Maryi f sho	ŏ	MD	St. Ma	ry's		Leon	ardtown					1 Yes 27 No
	28a	rec	10e. Street and Nu	ımber				10f. Zip Code			10g. Citizen o	of What Coun	itry?
	3a or	Ö	22500 Pc	oint Lool	kout Road				20650				,
	death	Funeral Director	11. Marital Status		12. Was Decedent E Armed Forces?	Ever in U.S	S. 13. V	Vas Decedent of H	dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	o- 14. R	USA lace - Americ	
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5-	n 72 h	iete	(Spec	15. Decedent's cify only highest g			(Give i	ent's Usual Occup kind of work done	during most of work	ing	16b. Kind of	Business/Ind	dustry
12	withir ane. than	m d	Elementary/Second 12	ondary (0-12)	College (1-4or 5	+)	IITO. L	OO NOT use retire	a)				
d 2	Hygie Hygie ther	ပိ	17. Father's Name		st)			cook	18. Mother's Nam	e (First, Middle		starau _{ame)}	int
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene	To Be	Leona	ard Love	11					cie Van			
<u>Z</u>	shoul nd Ma marl	1	19a. Informant's N	lame/Relationship	(Type, Print)		19b. Mailin	g Address (Street	and Number or Rur				Code)
Ž	alth a 27 is		Roxanne	Murow/d	laughter								
re,	s 1 a of Hea item		Roxanne Murow/daughter 5437 Chesnut Drive Racine, WI 53402 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Removal from State 5437 Chesnut Drive Racine, WI 53402 20c. Location - City or Town, State										wn, State
Ĕ	Page Tent c Int: If		1 Burial 2 Cremation 3 Removal from State '4 Donation 5 Other (Specify)										
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Itema 23a or 28a-1 show eny injury or other traumatic event, it a Medical Exandration ust be rediffed at once.		21. Signature	Onald S	wade /i/	<i>y</i> gr	22. S R	Name and Addre	tomy Boar MD 212	d 655 W	. Balt:	imore	Street
					mplications that caused	the death.							Approximate
	Physician		23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a Corebro Vous cular accident.) Approximate Interval Between Onset and Death										
	/Medical		resulting in death)	on	a. Due to (or as a			XWI CA	cciaori	1			
	Examiner				cothe	-	. 1	25					
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8760,	ate b hysic the b	d											
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Вох	The law requires that the death certifite has been signed by the attending vage 2 should be detached for use as	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day									ry Day Year	
Ö	he de	ysic	1 ☐ Yes 2 €	ØÑo	4□Pregnant at i 9□Unknown	time of dea	atn 5∐	Other (specify)					
ES .	that t ed by detar	/ Ph	Part II. Other signi	ficant conditions	contributing to death by	it not resul	ting in the un	derlying cause giv	ren ig Part I.	23e. Did t	obacco use co	ntribute to the	e cause of death?
MARIE CHARLES Vital Records, P.	urres tha signed I Id be det	d b		Chronic		well	owir	nanary	O. scare	10	Yes 2□No	3 Proba	abiy 4 @dnknown
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He H	he lav e has	ш	per die	ral Vi	De Char dise	erse.	Strol	ie with	aphasia	auto	osy ormed2	prior to con death?	rpletion of cause of
MARIE Vital R	icien: Th certificate rector, pag		25. Was case refer	rred to medical	7 0025				00 71	1 ☐ Yes	2 No	1 Yes	2 ☑ No
	Physicien: r this certific ral director,	To Be	examiner?	_	Hospital:	nt 2∏ F	R/Outpatient	3□ DOA Oth	26. Place of Death			that /Canada	
NE	g Phys er this eral di	n; T	27. Manner of Deat	th	28a. Date of Injur	у :	28b. Time of	28c. Injur	y at	28d. Describe			/
E io	ath. rr: Aft	atio	1 ☑ Natural 2 ☐ Accident	5 Pending investigati	(Month, Day	rear)	Injury	M 1 🗆	Yes 2 □ No				
ROSALENE Division of	or Attending riter death. Diractor: After in by the fune	tific	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine		ry - At hon	ne, farm, stre	et, factory, office		28f. Location (. City or To		nber or Rural	Route Number,
<u>⊠</u> <u>I</u>	talor Arsafter at Dirac	Certification;			January, 515	. (Opcony)				Ony or you	wii, Olaley		
	To the Hospital or Attending Physicien: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier (Check only one)	1 Certifying F 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner stat	examination	rledge, death on and/or inv	occurred at the tire estigation, in my o	me, date and place, pinion, death occur	and due to the red at the time,	cause(s) and r date and place	manner as sta e, and due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and	title of certifier			22.0	29c. Licens	e number		29d. Date sign	ned (Month, E	Day, Year)
			1 En				MIN	· D.	51738	-	6. 1	, 200	04
			30. Name and addi		o completed cause of de				WOOD MD	20636			
K	Sta Registr		31. Date filed (Mon	nth, Day, Year) 0 8 2004	32. Registra	r's Signati	No de	rocks					
		ĵ.	JUN I	0 0 4004			//						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Maria R. D'Addario June 2004 9:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2007 Vista Lane Timonium **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Director 213-64-8165 64 Sept. 19 1939 Brazil Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 3 No Director Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2007 Vista Lane death y 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 🗙 No Specify Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itan 27 is marked oth any injury or other traumatic event 9008. 18. Mother's Name (First, Middle, Maiden Sumame) Ernesto B. Gomes Maria Isabel Gomez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carlo D'Addario/husband 2007 Vista Lane, Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 6/7/04 Dulaney Valley Memorial Gardens Timonium, MD 21093 21. Signature of Funeral Sevice Line en ee 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093

enter the mode of dving, such as cardiac or respiratory arrest.

Appro Inc. Michael Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the human manner. Due to (or as a consequence of) P.O. Box 68760 Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 🗆 Yes 2.☐No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☐ No 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifie Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

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JUN 0 8 2004

31. Date filed (Month, Day, Year)

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

Sparks

	Ĭ.		1 - State Registrar	State of Marylan	d / Depa		ealth and I	Mental Hygie		14 1802
I	Physic /Medi		Decedent's Name (First, Middle, Last) MARGARET			Di	944	2. Date of Death Month	Day Year	
)	Examir	ner	4a. Facility Name (If not institution, give stands of the John S. Hopk 5. Social Security Number 6. Sex	kins Hospit	last birthday)	4b. City, Town, or L Button	_	ity	4c. County of De	ath N/A irthplace (State or Foreign
	Funeral Director		365-16-8762 ¹□ Usual Residence of Decedent	M 2 C□F 85	Yrs.	Months Days	Hours Min.	8. Date of Birth Month, Day Y March 2	(ar) 1919	Mi'chigan
	he Marylar 286-f show	Director	Md. Talbot 10e. Street and Number		appe					10d. Inside City Limits 1 ☐ Yes 2 🕍 No
	23a or	rai Dir	1795 Chancellor	Point Rd.		10f. Zip Code 216	73	109	. Citizen of What C	USA
036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or iteme 23a or 28e-f ahow avent, the Mcdiral Exeminational termitied at	by Funeral	11. Marital Status 1 Never Mamed 2 Married 3 Widowed 4 Divorced	 Was Decedent Ever in U. Armed Forces? 1	- 1	Was Decedent of Hisp f Yes, specify Cuban, I □ Yes 2 No	panic Origin? (Sp Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Arr Black, Wh Specify:	nencan Indian, ite, etc. White
21215-0036	within 72 ho lene. r than "natur the Mudical	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Specondary (0-12)		16a. Deced (Give life. L Homen	dent's Usual Occupati kind of work done du DO NOT use retired) Naker	on ring most of work	king 16	b. Kind of Busines:	,
Maryland	should be filed of Mental Hygie marked other matic avent, III	To Be C	17. Father's Name (First, Middle, Last) Carl J. Meurer				Marga	ne (First, Middle, Mai aret M. Ma	artin	
	is 1 and 2 should by Health and Men Item 27 is marke other treumatic		19a. Informant's Name/Relationship (Typ Patricia Daly/ Dau			g Address (Street and Chancell				
Baltimore,	permit. Pages 1 a Department of He Importent: If Item Iny injury or oth		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Hi	Iltop S	sition (Name of natory or other place) Service Co	. 6-3-	-04 1	C. Location - City o	
Ball	Departiment Departiment Important in once.		21. Signature of Filmeral Service Licenses		22	Name and Address Ruck Tows 1050 York	of Facility on Funer Rd. Tov	cal Home.	Inc 21204	
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,097	E xamine and sician and purial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Indertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (Or as a consequence to (or a))).	av te	ery disc	ense			30 years
O. Box 62	that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
ras, r	The law requires that ite has been signed b page 2 should be deta	by	Part II. Other significant conditions control	ributing to death but not resu	ilting in the un	derlying cause given	in Part I.	23e. Did tobac		o the cause of death?
Vital Records,		Completed	hypercholesterole	emia				24a. Was an autopsy performed 1 ☐ Yes 2	prior to death?	utopsy findings available completion of cause of
O	Phy this ald	ation: To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	spital: 1 Inpatient 2 2 8 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	3□ DOA Other: 28c. Injury at Work?	4 Nursing Ho	th (Check only one) me 5 Residence 28d. Describe how in		oify)
DIVISION	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify)			28f. Location (Street City or Town, St	ate)	
	he Hosp in 24 hos he Fune pletely fi	edical	29a. Certifier (Check only one) 1. Certifying Physic 2 Medical Exemine	cien: To the best of my know er: On the basis of examinati and manner stated.	vledge, death ion and/or inve	occurred at the time, estigation, in my opini	date and place, on, death occurr	and due to the cause red at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)
	To t With To 1	M	29b. Signature and that of partifier		ND	29c. License no	_	29d.	Date signed (Mont	h, Day, Year) 2004
	5		30. Name and address of person who com CHRISTOPHER HOFFA			Print) OLFE STREE	ET RAIT	TMARE MAR	OVI ANIA	21287
4 3	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signat	иге Д	Son V.	- , DALL	Links I IA	در سراحل	6-1 ton 1

State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 27, Geraldine de-Heer May 2004 Anthony 10:50 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery | STIVEL | SPILING | St. Date of Birth (Month, Day, Year) | 10/24/1952 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 51 577-70-2731 Wash. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28e-f show the Medical Examinar must be notified at VA Prince William Woodbridge 1 XYes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 13437 Kerr Ct. 22193 U.S.A. death by Funerai 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2000 Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Years Budget Analyst Dept. of Defense rmit. Pages 1 and 2 should be filed w ppartment of Health and Mental Hygier portant: If tem 27 is marked other tt iy injury or other traumatic event, III. other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William H.T. Anthony Irene Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Andrew N. de-Heer -Husband 13437 Kerr Ct. Woodbridge, VA 22193</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Harmony Mem. Park 06/04/2004 Landover, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Licenses 3821 14th ST, N.W. Wash, DC 20011 23a. Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Metastatic Endometrial Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner if or Attending Physician: The law requires that the death certificate be executed after death. iding physician and resulting in death) Last Due to (or as a consequence of) Box 68760, by Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 Yes 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2XXVo Certification: To 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 9 29b. Signature and title of certifier 29d. Date signed (Month, Dev. Year) erson who completed cause of death (Item 23a) (Type, Print) Holycross Hospited silvers

State Registrar

			For State	State of Marylai				lental Hyg		11. 10000
			Registrar 1. Decedent's Name (First, Middle, Las.	t)	Cei	tificate of D	eath	2. Date of Deat	ag. 140.	3. Time of Death
_	Physici /Medi		Leslie Davis	*				Month 06 - 0	_	1:55 PM
	Examir		4a. Facility Name (If not institution, give	2 4 2		4b. City, Town, or Lo	ocation of Death		4c. County of	Death
	Euperal		3403 FLANNERY 5. Social Security Number 6. Se	ANE 7. Age (In vrs	. last birthday)	If Under 1 Year	OAK f Under 24 Hrs.	8. Date of Birth	BALTIN	
	Funeral Director		250-36-3318	M 20 F 77	Yrs.		Hours Min.	8. Date of Birth (Month, Pay,	27	Birthplace (State or Foreign Country)
	and		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Mary a-f sho	tor	MD NIA		Po	Himme	í			1 Yes 2 □ No
	or 284	Direc	10e. Street and Number	1		10f. Zip Code		10	0g. Citizen of Wha	it Country?
	death with the Maryland ms 23e or 28e-f show r must be notified at	Funeral Director	3+03 FONNERY	12. Was Decedent Eyer in U	18 13 1	Mas Decedent of Hiso	anic Origin? (See	oifu Voc or No	<u>USA</u>	American Indian,
	6 after d or Itan		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No	'	Vas Decedent of Hisp Yes, specify Cyban,		Rican, etc.)	Black, \	White, etc.
	21215-0036 de within 72 hours af giene. Then "natural", or the Medical Exem.	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			Specify:		Specify:	BIACK
	n "nat	piete	15. Decedent's Edi (Specify only highest grad	de completed)	16a. Deced (Give life. I	lent's Usual Occupation Is work done dur NOT use retired)	on ing most of worki	ng	16b. Kind of Busin	ess/Industry
	212 212 3d with 2giene ar tha	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	P	4CKER			Mashes	s Ham
0	and the file	Be	17. Father's Name (First, Middle, Last)	Qa'		18	3. Mother's Name	(First, Middle, N	Maiden Sumame)	
>	Maryland nd 2 should be file lith and Mental Hy 27 is merked oth	To	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailin	g Address (Street and	VII QUIL	A OM I Route Number.	City or Town. Sta	te. Zip Code)
DA			Ruby L. Davis	(Wife)	3402	Flowner	zu Lane	Batti	more. M	D 21201
. 12	Baltimore, permit. Pages 1 a Department of Hes mportant: If Itam any injury or otha once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ f		Place of Dispo cemetery, cren	sition (Name of natory or other place)	0	ate 2	20c. Location - City	y or Town, State
Ä	Itim it. Pag intenti injury		 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service License)	Wood	Name and Address	678	-04	battimi	ore, mo
S	Bal permi Depar Impo any ir) augha C		~ 8°	128 Lihei	OLI PA	Som of	Teene Fi	inva sno.
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1	/Medical Examiner		resulting in death)	Due to (or as a consec	quence di:	000				
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V	60, be executed ician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. the	Ses.	Mell	n ho	>		
	cords, P.O. Box 68760, w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	al E	rooding in doubly Last	Due to (or as a consec	quence or):				,	
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	Box eath cert attendin for use	an/M	ZOD. Was decedent program	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta	ancy al death 3	Ectopic pregnancy			23d. Date of	,
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	bed by		Part II. Other significant conditions co	ntributing to death but not res	sulting in the ur	derlying cause given i	in Part I.	23e. Did tob	acco use contribut	e to the cause of death?
	equires	ed by	Pros	tale (ion	cer		1 ☐ Yes	s 200 3 E	Probably 4 Unknown
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	al R							perform 1 Yes 2	ed2 death	h? Yes 2□ No
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	n of ng Phy Iter thi		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury at Work?	2		w injury occurred	вреспу)
	SiOl tandir death. tor: Al	catio	2 Accident investigation 3 Suicide 6 Could not be			M 1 ☐ Yes	2 🗆 No			
	Division of Vital Records, to Attanding Physician: The law requires that death date death. The scrifficate has been signed in by the funeral director, page 2 should be control.	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, stre fy)	et, factory, office	2	8f. Location (Stre City or Town,	eet and Number of State)	r Rural Route Number,
	Division of Vital Rec To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2.		29a. Certifier Certifying Phy	sicien: To the best of my kno	owledge, death	occurred at the time,	date and place, a	nd due to the cau	use(s) and manner	r as stated.
	the Hohin 24 the Fumbletel	Medical	- Citey	iner: On the basis of examina and manner stated.	ation and/or inv					
	To To	~	29b. Signature and title of certifier	0 -		29c. License ni	Tutbet	29	d. Date signed (M	ontn, Day, Year)
	Z-5		30. Name and address of person who co	ompleted cause of death (Iter	m 23a) (Type, I	Print)	296		615/0/	+
	10			BATE 4	Wes	- polli	D j	Cofe	sulle	21)20
	Sta Registi		31. Date filed (Month, Day, Year) JUN 0 8 2004	32. Registrar's Sight	ature	longe	(0
	50 F-1		JUN U O LUGA	1	1- 1-	pour				

Sharon Suzette Dyson unpend item#23a,27,PER ME,C832,6/23/04eg
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-03708 amend item#late of Maryland / Department of Health and Mental Hygiene 6/08/04 JH
TTFM #17 PER FH G832 Certificate of Death Reg. No. / MAN 1- State Registrar AMEND ITEM #17 PER FH G832 Reg. No. 20 1. Decedent's Name (First, Middle, Last) Sharon Suzette Dyson 2. Date of Death 3. Time of Death ^{Day}2004 June 02, **Physician** SHARON SUZETTE EDWARDS 2053 P м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 27 Anderson Ridge Road Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 M 2 KF Min 218 82 3977 Yrs. MD Director 21 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits other traumatic avent. The Medical Examiner must be notified at BALTIMORE MD CATONSVILLE Director 1 Yes 2 No 28a-f filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27 Anderson 21228 RIDURE U.S.A. Itams 23s Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 1 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☑ Divorced 'natural' 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene.
If itam 27 Ia marked other than or other traumatic avent, If a Mental traumatic avent. Elementary/Secondary (0-12) College (1-4or 5+) Mental Service Coordinator 12th grade 17. Father Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be PAUL CLA PAUL EDWARDS ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edwards Ridge Rd atonsville MD 21228 Rose TAnderson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition bate 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department o Important: If any injury or once. 06/10/04 Baltimore, MD * 4 □ Donation 5 □ Other (Specify) ARBUTUS 21. Signatule of Funeral Service License 22. Name and Address of Facility
VALLETIN C. GREENE FUNERAL SERVICES
3151 BALTIMORE NATIONAL PIKE BALTO. ND 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hypertensive Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician Completed by Physician/Medical the as IF FEMALE: nse If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Nknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No 24a. Was an autopsy performed? 12 Yes 2 🗆 No or Attending Physician: after death.

Diractor: After this certified in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Certification: To 1 X Yes 2 🗌 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ₩ Other (Specify) At scene 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a peliil To tha Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 03, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MBID 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 0 8 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death ent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and to **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Kesaseake 3 Birthplace (State or Foreign 5. Social Security Number **Funeral** 213-28-3146 Months Days 1□M 2**X**F Hours Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location death with the Marylan 10d. Inside City Limits other treumstic event, the Modical Examiner was be notified at 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: or itams 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: W þ 3 ☐ Widowed 4 Divorced "natural" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within inent of Health and Mental Hygiene.
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Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or QDCE. /5 ☐ Other (Specify) Conco 21. Signature of Funera Service Licensee 22. Name and Address of Facility EVANIS FUNIERAL Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10cardia minutes /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
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Division of Vital Records, DOROTHY Medicai Certification; To completely filled in by the Director Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ō within 24 hours a To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D350/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave . BelAir , Md. 21014 State

Registrar

		-	For State Registrar	State of Ma	ryland / De	epartment of Certificate of	Health a f Death		giene 2001	+ 18032
			Decedent's Name (First, Middle, La	st)				2. Date of De.		3. Time of Death
	Physicia /Medic		Carolyn S. 1	Elliott				06	03 200	515 AM
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 (1) (1) Legible Certificate of Death

		•	For Stete Registrar		epartment of Health and Certificate of Death	Reg. N		10033
	Physicia		1. Decedent's Name (First, Middle, Last)	Epoblic	<u> </u>	2. Date of Death Month	Day Year	3. Time of Death
·	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Dea		Ic. County of Death	0
	Funeral Director		216-01-1900	KUX ton 7. Age (In yrs. last birth	Months Days Hours Min		SALT 9. Births Cour 3	MORE place (State or Foreign pity)
	Aaryland I show	ō	Usual Residence of Decedent 10a. State 10b. County A P P P P P	10c. City, Town	or Location			0d. Inside City Limits
	with the N s or 28s- be nutifi	Direct	10e. Street and Number	7-115 11	10f. Zip Code	10g. (Citizen of What Cou	ntry?
,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show important: If item 27 is marked other than "natural" or items 20a or 28a-f show any highly or other traumatic event, the Marical Examinar must be notified at ange.	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give	13. Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White,	
-003	2 hours a stural', or real Exec		3 Widowed 4 □ Divorced 15. Decedent's Edu	Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	16b.	Specify: C	hit
21215-0036	filed within 7 Hygiene ther then "n int, ire Med	Completed by	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	Give kind of work done during most of wo life. DO NOT use retired) ACH (V) ST	Re	herica,	Smelting
p	should be filed nd Mental Hygis marked other umatic event, II	To Be (17. Father's Name (First, Middle, Last) Rudolf. F	ROHLICH	Maria	me (First, Middle, Maid Wicke	·	
_	1 and 2 sho Health and om 27 is my ther traums		19a. Informant's Name/Relationship (Ty	ohlich JR. 3	Mailing Address (Street and Number or F	- Phoeni	V,MO.	16110
Baltimore,	Pages 1 ment of Hi ant: If iter ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 F 1 Donation 5 Other (Specify)	compton	Disposition (Name of crematory or other place)	8-04 B	Location - City or To	E MA
Balt	permit. Departi		21. Signature of Funeral Service License	Zewrotay	22. Name and Address of Facility B	ALTIMORE CHAPEL	5 MD 21	234. EFERDRO
	Physician		23a. Per(1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition	cations that caused the death. Do not cause on each line.	of enter the mode of dying, such as cardia	dent		Approximate Interval Between Onset and Death
A COLOR	/Medical Examiner		resulting in death)	Due to (or as a consequence or				
	cut ed nd transit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence or				
68760,	icate be executed physician and s the burial-transit	edicai Ex	resulting in death) Last	Due to (or as a consequence of):			
.O. Box 68	ath certifi attending for use a	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv Month	ery Day Year
Δ.	uires that the de signed by the a lid be detached	by P	Part II. Other significant conditions con	ntributing to death but not resulting in	the underlying cause given in Part I.		o use contribute to t	he cause of death?
of Vital Records,	The law require ate has been si page 2 should t	ompieted				24a. Was an autopsy performed	prior to co death?	opsy findings available impletion of cause of
ital		Bec	25. Was case referred to medical examiner?			eath (Check only one)		
of V	Sir din	၉	1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ ER/Out 28a. Date of Injury 28b. Ti		Home 5 Residence		(y)
	ding Ih. After funer	tion	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		me of 28c. Injury at Work? M 1 □ Yes 2 □ No	23d. Describe now ii	ijury occurred	
Division	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: Attent completely filled in by the funera	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Street City or Town, St	and Number or Run ate)	al Route Number,
	e Hospite 124 hours te Funere	Medical C			death occurred at the time, date and place for investigation, in my opinion, death occ			
)	To the To the comp	M	29b. Signature and title of certifier	elio.	29c. License number 140054424	1	Date signed (Month,	
			30. Name and address of person who co	completed cause of death (Item 23a) (20 E Timoniur	Type. Print) m rd. Suite 209	Timonium,	, MD 2	1093
47	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature				

DHMH 17 Rev 1/2001

JUN 0 8 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** June Francis 02 1825 QUINN , 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAHMORE
If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 F Yrs. Director 218-55-0399 08/15/1999 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int If item 27 is marked other then "natural", or Itams 23e or 28e-f ehow 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Itams 23a or 28a-f ehow solical Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1205 Jewelweed Path 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic evant, In Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) INFANT IN FANT INFAW? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sean F. Francis ပ Amy R. DiRocco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1205 Jewelweed Path, Pasadena, MD 21122 Sean Francis/Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ^ 4 □ Donation 5 □ Other (Specify) Cedar Hill Cem 06/07/04 Baltimore 22. Name and Address of Facility G.J.Gonce Funeral Home, 21. Signature of Funeral Service Licensee 169 Riviera Dr., Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory DISTRESS Week disease or condition resulting in death) /Medical Examiner Lymphoblas 20 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death 5 Cther (specify) P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Versus Host Disease 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 No Yes 2 No 1 TYes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 Z No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Z Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide e Funeral (29a. Certifier 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only within 2 the e 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) RES-000 June 02, 2004 b 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/200

State

Registrar

Christopher T.

Day, Year)

JUN 0 8 2004

ORIGINAL

600 North

MCKee DO.

32. Registrar's Signature

Baltimore MD

ST

			State Amend Items#1,1	ate of Maryland / De 2&17,per DR/FIP	partment of Health ertificate of Death	and Mental Hy	ygiene Reg. No. 2004	18035
	Physici		1. Decedent's Name (First, Middle, Last) Joseph	seph Edward Fel	ton Jr.	2. Date of D Month	Day Year 2006	3. Time of Death
	/Medio Examin Funeral Director		4a. Facility Name (If not institution, give street Can Lin Square 5. Social Security Number 6. Sex 246-36-0647	7. Age (In yrs. last birthd	Months Days Hours	of Death or 24 Hrs. 8. Date of B	4c. County of Dear BOITIN irth Pay, Year) 9. Birth Co	
death with the Maryland	show		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits 1√ Yes 2 No
he M	28a-f.s	Directo	Md. NA	Ba	altimore 10f. Zip Code		10g. Citizen of What Co	
with	l be		1324 Maple Ave.		21221		USA	onay:
Te.	e an "natural", or itams 23a or 28a-f show Medical Examiner must be notified at	by Funerai	11. Marital Status 1 Never Married	as Decedent Ever in U.S. med Forces? Aves 2550 Aves 2550 per or Dates 1951–1957	3. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 Yes 2 No Specif	an, Puerto Rican, etc.)	lo- 14. Race - Ame Black, Whit	
within 72 hours at	e. An "natur Medical	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)	pleted) (G lift ollege (1-4or 5+)	cedent's Usual Occupation ive kind of work done during me e. DO NOT use retired)	ost of working	16b. Kind of Business	
N D	l Hygien other th		12th grade 17. Father's Name (First, Middle, Last)		Ladle Liner	her's Name (First, Middle	Beth. St	eel
Maryland d 2 should be file	Mental arked c	To Be	Joseph - Edwar		Sr. Ro	osa	Shannon	Zin Codo)
Man d2st	7 is 7 is trau		19a. Informant's Name/Relationship (Type, P. Marlene D. Felton		ailing Address (Street and Num	- 35 .	% 800 a a a	21p C00e)
altimore, N	or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remov	20b. Place of Di cemetery,	324 Maple Ave., sposition (Name of crematory or other place)	Baltimore, Date	20c. Location - City or	
			 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 	Holly	Hill Cem.	6-4-04	Middle Riv	er, Md. 1202
Balt permit.	Dep any onc		> Gladus	Wome		Darchi	E. North A	
3760, at the second of the sec	ohysician and Medical kaminer the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last d	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	nock			Interval Between Onset and Death
O. Box 68	y the attending ph ched for use as the	Physician/Me	in the past 12 months?	yes, outcome of pregnancy Live birth 2 Fetal death Pregnant at time of death Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of del Month	livery Day Year
Records, P.O The law requires that the	n signed by the a uld be detached f	b	Part II. Other significant conditions contribut	ting to death but not resulting in th	e underlying cause given in Par		tobacco use contribute to	o the cause of death?
		Completed				per 1 \(\text{Yes}	opsy formed? prior to death? 2 No 1 □ Yes	utopsy findings available completion of cause of
	Scertif	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospit	al: 1 ☐ Inpatient 2 🛣 ER/Outpa	Othor	ce of Death (Check only	rone) sidence 6 □Other (Spe	cifu)
Division of Vita	ith. : After this e funeral d	H	- A	a. Date of Injury (Month, Day Year) 28b. Tim Inju	e of 28c. Injury at	28d. Describe	how injury occurred	olly)
Divis al or Atta	s after death	Certification:	3 Suicide 6 Could not be determined 28	e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location City or To	(Street and Number or Roown, State)	ural Route Number,
10 Hospita	within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	(Check only 2 Medical Examines: 0	n: To the best of my knowledge, d On the basis of examination and/o and manner stated.				
Toth	7	Me	29b. Signature and title of certifier	- A Alu	29c. License numbe	8762	29d. Date signed (<i>Mont</i> 5 - 3 <i>C</i>)	h, Day, Year)
	10		30. Name and address of person who comple	ted cause of death (Item 23a) (Ty	po, Print) Solvere Dri	ve Baltin	nore, 1110	31337
	St: Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Soular	13.0		

			For	State of		d / Depa	artmer		ealth and M	-	ygiene	20		1802
			Registrar	Idle I ast		Oei	uncai	ie oi L	- Call	2. Date of D	Reg. No.		U 19	3. Time of Death
	Physicia	an	1. Decedent's Name (First, Mid	Die, Last)		1.				June			ear	2:35 AM
	/Medic	al .	Florence			+/,	nne	4				20	Marie Company	X.72 4
	Examin	er	4a. Fecility Name (If not institut						Location of Death	1		County of I		6 4
			Good Samari			C		M. Shar	If Under 24 Hrs.	O Data of E	i de	al Ho	District.	City - English
	Funeral Director		5. Social Security Number 216-36-7001	6. Sex 7.	91	Yrs.		Days	Hours Min.	8. Date of B January	15.191	13 Ma	aryla	ce (State or Foreign Nd
yland	Now Int		Usual Residence of Decedent 10a. State 10b. Cour	ity	10c. City	y, Town or Lo	cation			 			100	d. Inside City Limits
э Маг	28a-f ehow	ctor	Maryland Bal	timore	Coc	ckeysvi	lle							1 □ Yes 2 📈 🔭
death with the Maryland	23a or 28a-f ehovust be notified at	I Director	10e. Street and Number 10323 Malcolm	Circle Apt	Ε			p Code 21030)		10g. Citiz	en of Wha	it Countr	y?
death	ms 2	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.	.S. 13.	Was Dece	edent of His	spanic Origin? (Sin, Mexican, Puert	pecify Yes or N	10- 1	4. Race -	Amenca White, et	
9	l', or Items 23a xaminar must	by Fur	1 Never Married 2 M	If Yes Give		1		ХХХю	Specify:	o nican, etc./		Specify:		ite
1215-0036 within 72 hours after	'natural', dical Exe	eted	15. Deced	ent's Education hest grade completed)		16a. Dece	dent's Usu	ual Occupa	ution furing most of wor	king	16b. Kin	d of Busin	ess/Indu	istry
2121 d within		Completed	Elementary/Secondary (0-12		4or 5+)		keep					Ret	ail	
Maryland 21215-0036	nd Mental Hygien marked other th matic event, Ita	To Be C	17. Father's Name (First, Midd Howard Wilson						18. Mother's Nan Florer	ne (First, Midd nce Kel		Sumame)		
Shou	th and Mer 7 Is marke treumatic	_	19a. Informant's Name/Relation	nship (Type, Print)		19b. Mailir	ng Addres	s (Street a	and Number or Ru	ral Route Num	ber, City or	Town, Sta	ite, Zip C	Code)
	27 Is		Lee M Seabolt	Ner	ohew	1822	Notr	e Dan	ne Avenue	e Luthe	rvill	e, Ma	ryla	ind 21093
5	item 27 other tr		20a. Method of Disposition		20b. P	Place of Dispo emetery, crea	sition (Na	ame of	9)	Date	20c. Loc	cation - Cit	y or Tow	n, State
70 30e	at: If i		1 X Xurial 2 ☐ Crematic	n 3 Removal from St		rkwood			6/5	/04	Balt	imore	, Ma	ryland
Baltimore,	Department of Important: If i any injury or one.		21 Signature of Funeral Servi		akc	22	2. Name a	and Addres	s of Facility Mit	chell-Wi k Road E				
	ž		23a. Part1. Enter the disease shock, or heart failure. L				ter the mo	ode of dying						Approximate nterval Between Onset and Death
	hysician /Medical xaminer		disease or condition resulting in death)		r as a conseq									ays
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (o	r as a conseq	juence of):								
D, C	an and rial-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (o	or as a conseq	ruence of):								
68760,	physicia s the bu	edical		d										
Division of Vital Records, P.O. Box 68760,	r the attending physician and ched for use as the burial-transit	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		th 2 Feta int at time of d	aldeath 3	⊒Ectopic □ Other (s	pregnancy specify)			- 2	3d. Date o Month		/ ⊘ay Year
IS, P.	signed by the	by Ph	Part II. Dther significant cond		ath but not res	sufting in the u	ınderlying	cause give	en in Part I.		d tobacco us			cause of death?
corc	been s	leted	Polison	1016						24a. Wt		24b. Wei	re autops	sy findings available
I Re	certificate has been si rector, page 2 should I	Completed								au pe 1 ☐ Yes	topsy formed? 2 No	dea	th?	pletion of cause of
/ita	ertific ector,	Be	25. Was case referred to med examiner?					04	26. Place of Dea	ath (Check only	y one)			
Division of Vital Records,	h. After this c funeral dire	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of		ER/Outpatien 28b. Time of Injury		28c. Injury Work	at Nursing F	lome 5 Re 28d. Describ			(Specify)	
io i	death. ctor: Aff	atlo	Z [] Accident	estigation	,,,	, , , ,	М		Yes 2 □ No					
Divis	after de Directo	Certification:			of Injury - At h g, etc. (Special		reet, facto	ory, office		28f. Location City or 7	(Street and own, State)	Number (or Rural	Route Number,
- 000	within 24 hours after death, within 24 hours after death, to the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)	fying Physician: To the I cal Examiner: On the ba and mann	sis of examina	owledge, deat ation and/or in	th occurre	d at the time on, in my op	ne, date and place pinion, death occu	e, and due to the arred at the tim	ne cause(s) e, date and	and manne place, and	er as sta I due to t	ted. he cause(s)
40 40	within 2 To the comple	Mec	29b. Signature and title of cer		o. statou.		2	9c. License	e number		29d. Date	e signed (A	Month, D	ay, Year)
			XIM	Zin			۵	005663	+		Mue	03	200	4
	1		30. Name and address of pers	on who completed cause	of death (Iter	m 23a) (Type	, Print)		. 10 0	Ú.				1
	10		Lee Gay de	Jean mo	3601 L	Oche R	even	20 500	d Bal	There	ma	0-11	139	
₩ 4	St Regist	ate rar	31. Date filed (Month, Day, You JUN 0 8	2004	ig ii		pyou							

			1 - For State Registrar	State of Marylar		rtment of H			/	004	18037
	Physici	an	1. Decedent's Name (First, Middle, Last)) Frai	nhlin	S'R	D Gatti	2. Date of De	ath Day	Year	3. Time of Death
	/Medic Examir	al	4a. Facility Name (If not institution, give s	street and number)	1/////	4b. City, Town, o	r Location of Dea	JUNE	4c. Cou	2004 nty of Death	4:43 AM
			SAINT AGNES 5. Social Security Number 6. Sex	11-1-1-1-1	ARE	If Under 1 Year	LTIM (-	NIF)	
U	Funeral Director		218-28-8722 12	7. Age (In yrs	Yrs.	Months Days	Hours Mir		1932	WAS	lace (State or Foreign
	yland now		Usual Residence of Decedent 10a. State 10b. County		ity, Town or Loc			,		1	Od. Inside City Limits
	he Mar 8a-f sh	Director	MD NA	180	Utimor		 -				1 ☐ Yes 2 ☐ No
	72 hours after death with the Maryland natural; or itams 23a or 28a-f show Jisal Evaninat Frust be rodified at		204 Diener	Place.	Apt. 302	10f. Zip Code	39		USA	of What Cour	try?
	itams	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces? 1 ☑ Yes 2 ☐ No		/as Decedent of H Yes, specify Cuba	lispanic Origin? (an, Mexican, Pue	Specify Yes or No- nto Rican, etc.)		Race · Americ Black, White,	
21215-0036	ours af	by	3 Widowed 4 Doivorced	If Yes, Give Year or Dates:	1	☐ Yes 212 No	Specify:		Spe	city: B/	ack
215-(nin 72 hours n "natural", Madical Exa	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Şəəpndary (0-12)	e completed)	(Give I	ent's Usual Occup ind of work done O NOT use retired	during most of w	orking	Andrew	Business/Ind	dustry
	filed withln Hygiene. Ithar than "		17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Lab	orer	10 Marks -d - N	Control Asia	101	re Co.	
land	2 should be filed withli and Mental Hygiene. is marked othar than aumatic evant, the M	To Be	Unk.				Unk.	ame <i>(First, Middl</i> e,	Maiden Sun	name)	
Maryland	iii. Pages 1 and 2 should be filed within 72 ho criment of Heatin and Mental Hygiene. rtant: if item 27 is marked other than "natur njury or other traumatic event, the Medical		19a. Informant's Name/Relationship (Ty)	ре, Print)	19b. Mailing	Address (Street		Rural Route Numbe	r, City or To	wn, State, Zip	Code)
	es 1 and of Health fitam 27		20a. Method of Disposition		Place of Dispos	ition (Name of atory or other place	(8)	Date	20c. Location	on - City or To	wn, State
Baltimore,	permit, Pages Department of I Important: if it any injury or o		1 Burial 2 Oremation 3 □R 1 Onation Other (Specify) 21. Signature of buneral Service License	1 1901	- 0	orest Ve	21. 6-1	11-04	Owing	s mil	is, mo
Ba	permit. Deportuimporti		21. Signature dysumeral service License		Ga	Name and Addres	ch Flif a	70 Fred	hi Iton t	ass Ba	Ho. 1115
			23a. Party Ent the disease, or compliant shick, or earl failure. List only on	cations that caused the dea	th. Do not ente	r he mode of dyin	ng, such as cardi	ac or respiratory ar	the state of the s		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Zause (Final disease or condition resulting in death)	Due to (or as a conse	QNIA					(lays
	Examiner	_	Sequentially list conditions,	Due to (or as a conse	COB	STRUC	TIVE	PULMON	ARY I	DISTAS	I years
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		querice or).						V
8760,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a conse	quence of);						
9	ntificate ing phys a as the	Medicai	IF FEMALE:								
Вох	death certific e attending p id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3 □	Ectopic pregnancy Other (specify)				Date of delive Month	ry Day Year
P.O.	that the de ed by the a detached	Physi	9 🗆 Unknown	9□ Unknown	-						
rds,	sign d be	by	Part II. Other significant conditions con DEMENTIA	tributing to death but not re	sulting in the un	derlying cause giv	en in Part I.	23e. Did to	_		e cause of death? ably 4 []Unknown
Records,	law requires been 2 shoul	Completed	7					24a. Was autop		b. Were autor	esy findings available
Vital B		e Con	25. Was case referred to medical				00 Pt (0)	perfor 1 ☐ Yes	med? 200 No	death?	2) No
of Vi	d is	To B	examiner?	lospital: 1 Inpatient 2	ER/Outpatient	3□ DOA Oth		eath (Check only of Home 5 Resid		Other (Specify)
	0 0 0	tion:	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work	y at k? Yes 2 □ No	28d. Describe h	ow injury occ	urred	
-	- 9 -	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h	nome, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Nu n, State)	mber or Rurai	Route Number,
Ω	To the Hospital of within 24 hours after the Funaral completely filled in		29a. Certifier 1 Certifying Phys	sician: To the best of my kn ner: On the basis of examin	owledge, death	occurred at the tin	ne, date and place	e, and due to the o	ause(s) and	manner as st	ated.
	the Ho	Medical	(Check only one) 2 Medical Examination Medical Examination Medical Examination (Check only one)	ner: On the basis of examin and manner stated.	ation and/or invi						
)	T wi			Merca	M.D.	29c. Licenso		-		ned (Month, L	-
	1	1	30. Name and address of person who co		m 23a) (Type, F	rint)	IE DA	TIMORT	MA	21// ^	N(D 21220
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign			NE , 0/40	- I III O K t	11/4	NYLA	1177 ×1459
	Registi	ar	111N A 8 2004	Genetia	4 1	-11					

ORIGINAL

FRANKLIN

GILBERT

State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** June 4, 2004 Bertha С. 3:00 a Feelev /Medical 4c. County of Death 4e. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carrol1 1203 Marclee Road Finksburg If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) April 10, 1927 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 🖾 F 77 Yrs. Pennsylvania Director 103-20-4089 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28e-f show ir than "natural", or Items 23a or 28a-f shov The Medical Examinar must be notified at 1 ☐ Yes 2 No Director Finksburg Carroll MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21048 U.S.A. 1203 Marclee Road within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes 2 🔀 No Yes, Give 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White If Yes, Give Year or Dates: þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Banking Clerk 10 is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be f and Mental h Catherine Guda Baltazar Galban 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum <u>once</u>. Finksburg, MD 1203 Marclee Road Daughter Debra Serrano 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ⊠Burial 2 □Cremation 3 □Removal from State Long Island Nat. Cem. Long Island, NY * 4 ☐ Donation 5 ☐ Other (Specify) 11824 Reisterstown Road 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ELINE FUNERAL HOME Reisterstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cahcen /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Cher (specify) detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 53 E Know4 1 Yes 2 No 3 Probably 4 Monknown Be Completed 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate ha Division of Vital 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: After Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 T Homicide within 24 hours at To the Funeral D completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier , M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center St. Westminster Md 2115 Paintz M.D 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2 Date of Death 1. Decedent's Name (First, Middle, Last) Jun 3, 2004 12:25 AM. M **Physician EDNA** FLEET /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore CATON MANOR | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Aug 23, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Maryland **Funeral** 1 □ M 2X□ F 75 217-24-8053 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 No Baltimore N/A Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21230 2818 Maisel Street Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 (▼Never Married 2 Married Black 1 ☐ Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Home College (1-4or 5+) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ethel B. Fleet Leroy H Fleet 2 Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21230 2818 MAISEL ST. BALTO. MD. tof Health: TIMOTHY FLEET other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or c 1 Burial 2 □ Cremation 3 □ Removal from State Landsdown, Maryland 06/09/04 Mt. Zion 4 □ Donation 5 □ Other (Specify) 22. Name and Addr ESTEP 1300 ET Address of Facility EP BROS. FUNERAL HOME P.A. EUTAW PL. BALTO. MD. 21217 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC MONTHS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician for use as the buria Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 DEctopic pregnancy Day Month in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No ed by the detached Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 2 No certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check on one Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No this in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Ceath After 1 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. within 24 hours after death
To the Funeral Director:
completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 who completed cause of death (Item 23a) (Type, Print) BATTIMURE 821 WE THO CEA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUN 0 8 2004

DHMH 17 Rev 1/2001

ORIGINAL

p.m.

8:30

2004

2,

FREEMAN

WILLIAM

 Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year Jun 9, 1947 Months Days Hours tx□ M 2 □ F Director 219-50-1692 56 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State Item 27 is marked other than "natural", or Items 23e or 28e-f show other traumstic event, Ite Nedical Exact from the routilised at X 1 ☐ Yes 2 ☐ No Baltimore N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with U.S.A. 21216 3407 Piedmont Ave. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1x☐Yes 2☐No If Yes, Give 1967 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Black Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 Divorced Year or Dates: 1973 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Coppin State Collage and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Police Officer 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sallie M. Freeman å William Calvin Freeman Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3407 Piedmont Ave. Baltimore, Maryland 21216 it of Health Mertha Freeman Wife altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ 06/09/04 Owings Mills, Maryland Department of Important: If any injury or once. Garrison Forest Veterans Cemetery ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Estep Brothers Funeral Home P.A 21. Signature of Fymeral Service Licensee 1300 Eutaw Place Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PANCREATIC CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit death certificate be executed Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 TUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy 2∏ No 1 Yes 2 No 1 🗌 Yəs Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home ٩ 1 🗌 Yes ZXX No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Cher (Specify) HOSPICE s after dee... ral Director: After ... hy the funeral d of this 28b. Time of 28a. Date of Injury (Month, Day 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 147125 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 DR. TARIQ MAHMOOD 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State Registrar JUN 0 8 2004 DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

William Calvin Freeman, Jr.

7. Age (In vrs. last birthday)

Stella Maris (Dulaney Valley)

6. Sex

Reg. No./

Jun 2. 2004

4c. County of Death

Baltimore

3. Time of Death

B:30 PM.

2. Date of Death

Month

		_1	For State Registrar		epartment of Health and M Certificate of Death	Reg. I	2004	18041
45	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) FRANK W. HI	ock .			Day Year 2004	3. Time of Death 9:29 P M
>	Examin		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death		4c. County of Death	
	Funeral Director		216-13-1	7. Age (In yrs. last birth	BALTIMORE CITY If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye.	9. Birthpl Gount 134 Mar	ace (State or Foreign
	ow ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		10	Od. Inside City Limits
	a-f sh	ctor	CAM	Balti	MORE			1 Yes 2 No
	or 28	Director	10e. Street and Number	0.1.04	10f. Zip Code	10g.	Citizen of What Count	try?
	eath v	Funeral	28/2 E MORHUM	2. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - America	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic avant, Ite Modical Examitier must be rutified at anse.		1 Never Married 252 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 (VNo Specify:	Rican, etc.)	Specify: Who	ite
215-0036	72 ho "natur	Completed by	15. Decedent's Educ (Specify only highest grade		Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16b	. Kind of Business/Ind	ustry 10:10 1
2121	filed within Hygiene. Ither then "unt, II e Mes	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	ONTRACTOR	4	egiempi	whea
	be filed ital Hygie od othar avant, II	Be C	17. Father's Name (First, Middle, Last)	014.11	18. Mother's Nam	e (First, Middle, Maid	den Sumame)	
Maryland	should be ind Mental s marked o umatic ave	To	FRUIK N.	610CK	Mailing Address (Street and Number or Rur	a P to Number Ci	War Town State Zin	Code) 7/7/5
Mar	d 2 sho th and th is mu trauma		19a. Informant's Name/Relationship (Ty)	1X1() - (1)11a 2)	PLA C. Markher W	PKW B	n Otimo E o	M/)
ē,	is 1 and if Health itam 27 other tr		20a. Method of Disposition	comptan	Disposition (Name of y, crematory or other place)	Date 20c	Location - City or To	wn, State
imo	Pages ment of I ant: If its ury or o		1 Surial 2 Cremation 3 R	Oak	awn Come. 20	04 B	autimore.	MD
Baltimore	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service License	Wells	22. Name and Address of Facility EV	ans fun Baction	repal Chap	21234
			23a. Part1. Enter the disease, or complished, or heart failure. List only or	cations that caused the death. Do not cause on each line.	not enter the mode of dying such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of	to ladio such	r His	en	
	Examiner		O and the first are distance)	.,,			
	D ##	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):			
	and and II-trans	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence	of):			
8760	icate be executed physician and s the burial-transii	edical E	L,	d				
9	certificat Iding phy Ise as th	Medi	IF FEMALE:					
O. Box	death e atter	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ny Day Year
rds, P.	w requires that the been signed by th should be detache	b	Part II. Other significant conditions co.	ntributing to death but not resulting in	n the underlying cause given in Part I.		co use contribute to th	E a
Vital Records,	n: The law reicate has bee	Completed				24a. Was an autopsy performed 1 Yes 2	prior to cor death?	psy findings available appletion of cause of
/ita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	Other	th (Check only one)	/	
of	ding Physical After this of funeral directions	on: To	27. Manner of Death → Natural 5 Pending	28a. Date of Injury 28b.	Firme of njury at Work?	28d. Describe how	e 6 □Other (Specify injury occurred	/)
Division	Attanding or death. actor: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, fa			at and Number or Rura	l Route Number,
Div	al or A s after il Dira	Serti	4 Homicide : determined	building, etc. (Specify)		City or Town, S	orare)	
	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the f	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my knowledge iner: On the basis of examination an and manner stated.	e, death occurred at the time, date and place d/or investigation, in my opinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	11 /8	29c. License number		Date signed (Month,	-
	7		1 looden	Me KTS mes	OCME	JU	UNE 5, 200	4
	1,	,	30. Name and address of person who co		(Type, Print) 111 Penn Stree	et, Baltim	ore, Marvl	and 21201
	St Regist	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signature	Spark			

		1	For State Registrar	State of M	Maryland / Depa	artment of Hertificate of L		nd Mental I	Hygiene Reg. No.	711116	18042
			1. Decedent's Name (First, Middle	, Last)				2. Date of Month	Death Day	y Year	3. Time of Death
	Physicia /Medic	al .	George L. G			1		06/	05/2	004	1:45 A ^M
	Examin		4a. Facility Name (If not institution,		er)	4b. City, Town, or		f Death	1	. County of Death	
			7820 Summit 1		Age (In yrs. last birthday)	Pasaden	I a. If Under 2	24 Hrs. 8. Date o	Birth	nne Aru	nplace (State or Foreign untry)
	Funeral Director		215-24-0824	1 X M 2□ F	76 Yrs.	Months Days	Hours	Min. (Month	Day, Year)	27	MD
	D		Usual Residence of Decedent								10d Incide Oile Limite
	arylan show d bit	_	10a. State 10b. County		10c. City, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 No
	Ne Ma	Director		Arundel	Pasade	na 10f. Zip Code			10g Cit	izen of What Co	
	with the	Ö	10e. Street and Number							.S.A.	unity
	leath	Funerai	7820 Summit	12. Was Decede	nt Ever in U.S. 13.	21122 Was Decedent of Hill Yes, specify Cubar		in? (Specify Yes o		14. Race - Amer	
ဖွ	after o	표	1 ☐ Never Married 2 🛣 Marri	ed 1 K Yes 2 (s? □ ^{No} 1945-	If Yes, specify Cubar 1 ☐ Yes 2 X No	n, Mexican, Specify:	, Puerto Hican, etc)	Black, White	
215-0036	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show item Evar it wit towat be rectified at	d by	3 Widowed 4 Divorced	Year or Date	s: 1946					Specify: Wh	
5-(n 72 h	Completed	15. Decedent (Specify only highes	's Education t grade completed)	/Give	dent's Usual Occupa kind of work done a DO NOT use retired.	lurina most	of working	16b. K	ind of Business/l	Industry
212	within ene. then	duc	Elementary/Secondary (0-12)	College (1-4	or 5+)	pervisor			Ea	astern	Products
d 2	illed Hygi other ent, I	Be Co	17. Father's Name (First, Middle,	Last)				r's Name (First, Mi			
<u>la</u> n	Mental I Merked o arked o	To B	George L. G	eisendaff	er		Mar	guerite	Ste	infort	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene 1. Health and Mental Hygiene 1. Health and Mental Hygiene 1. The Medical Exp. il the 1. And the recitified at the treumatic event, the Medical Exp. ill at 1. And the recitified at	1	19a. Informant's Name/Relationsh			ng Address (Street a			_		
	of Health item 27		Margaret Gei	sendaffer	/Wife 782		Rd.	, Pasad	ena,	MD 211 ocation - City or	Z2
Baltimore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		te cemetery, cre	matory`or other place					
III III	it. Pa rtmen rtent: njury	1	* 4 □ Donation 5 □ Other (S) 21. Signature of Funeral Service			Pk Cemet 2. Name and Addres					
Ba	permit. Page Department. Importent; If eny injury o		21. Signature of Fundamental Styles	2		69 Rivie					
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau only one cause on eac	sed the death. Do not en h line.	ter the mode of dying	g, such as	cardiac or respirato	ry arrest,		Approximate Interval Between Onset and Death
	Pnysician	- 0	Immediate Cause (Final disease or condition	-a. Lu	na Cance	1				i i	Onser and Deam
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):						
		7	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequence of):						
	uted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	(
Ć.	executed in and ial-transii	Exa	resulting in death) Last	Due to (or	as a consequence of):		-				
760,	te be ey ysicien ye buria	ical		d						-	
99	ntifica ng ph as th	P	IF FEMALE:				-				
Вох	eath certific attending pl	Physician/M	23b. Was decedent pregnant in the past 12 months?		n 2 Fetal death 3	☐Ectopic pregnancy				23d. Date of deli Month	iv ery Day Year
	t the dea by the a tached for	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐ Pregnan 9□ Unknow		Other (specify)			_		
P.0	es that thighed by be detact	/ Ph	Part II. Other significant condition	ons contributing to deat	h but not resulting in the	underlying cause give	en in Part I.	23e.	Did tobacco	use contribute to	the cause of death?
ds,	uires r sign ld be	d by	Coronan	1 arlang	Disease				1 ☐ Yes 2	□No 3□Pr	obably 4 DUnknown
00	w requ	lete	Chronic (Obstruchu	Disease e Pulmoni	ury Diseus	e		Mas an	24b. Were au	topsy findings available completion of cause of
Re	The law ate has page 2 :	Completed		Cancer					autopsy performed? es 2 No	, death?	2 No
ita	iclen: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?					of Death (Check of			
) \	Physicle this cert al direct	၉	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inp				rsing Home 5 🕩			cify)
Division of Vital Records,	ding P. J. After t	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	ig .	Injury Day Year) 28b. Time Injury	Worl	/at k? Yes 2⊡I		ribe how inju	ry occurred	
isio	ttendi death. ctor: A / the fu	icat	2 Accident investi	not be 390 Phon of	i Injury - At home, farm, s		103 2		on (Street ar	nd Number or Ru	ıral Route Number,
Ď	after of Direct	Certification:	4 ☐ Homicide determ	building	, etc. (Specify)			City o	r Town, State	e)	
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1☑ Certifyir	ng Physician: To the b	est of my knowledge, dea	th occurred at the time	ne, date an	d place, and due to	the cause(s) and manner as	stated.
	n 24 l	Medicai	(Check only 2 Medical one)	end manne	is of examination and/or i r stated.	nvestigation, in my of	pinion, dea	th occurred at the t			
	To the To the Comp	Σ	29b. Signature and title of certifie	r 100 -		29c. License	0000	7	1	te signed (Monti	10011
	. i		> Julian of	11		05	8959		1	110 0	7
	10+1		30. Name and address of person Jolene Brow	n 10 10 0	of death (Item 23a) (Type	Speet B	alhm	zore Mev	rland	21201	
	. St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Reg	gistrar's Signature	Print) Spect B					
		7.5									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death MonthJUNE Day 5. 20164 Physician 3:15 S. William Galvin /Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Center **Examiner** OWSON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 26, 1930 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1**X** M 2□ F Maryland 73 213-30-5579 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or Items 23a or 28a-f show the Modical Examinar must be notified at 1 Yes 2 No Director Towson MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21286 USA 524 Hampton Lane death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Yes, Give ear or Dates: Specify: Completed by 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Horstmeir Elementary/Secondary (0-12) College (1-4or 5+) Executive Lumber Company marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fit ment of Health and Mental H sant; If item 27 Is marked ott Dr. Thomas K. Galvin Sarah Westcott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Janet McFee Galvin / wife 524 Hampton Lane; Towson, MD 21286 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. Hilltop Service Corp. 6/10/04 Towson, MD ` 4 □ Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility 1050 York Road eter Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death I HUURS Immediate Cause (Final disease or condition resulting in death) LEFT CEREBRAL ACCIDENT **Physician** /Medical Due to (or as a consequence of):
ACUTE MYOCARDIAL INFARCTION 8 HOURS **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit HYPERCOAGULABLE STATE 1 YEARS and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician 5 YEARS METASTATIC PROSTATE CANCER Completed by Physician/Medical as use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year for in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2X No 24a Was an rmed? certificate 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Yes 2X No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: 1 X Natural 5 Pending s after dec. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide To the Hospitel o within 24 hours aft To the Funerel Di 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Mars, 10 D 16587 6, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANG. 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year)
JUN 0 8 2004 32. Registrar's Signature State Registrar

		1	For State Registrar	State of Maryland		ent of Health and ate of Death		giene Reg. No. 2004	18041
	Physicia	an	1. Decedent's Name (First, Middle, Last CARL PL GU	•			2. Date of Dea Month 0.5	Day Year	3. Time of Death D6:35 PM
	/Medic Examin		4a. Fecility Name (If not institution, give	street and number)		ity, Town, or Location of Dea	MD	4c. County of Deeth	
5	Funeral Director		5. Social Security Number 6. Security Number 1. Control of the security Nu	x 7. Age (In yrs. last → M 2□ F	Yrs. If Un-	der 1 Year II Under 24 Hr ns Days Hours Mir	(Month, Da	y, Year) 9. Birthpla Count 9. 1916 Mary	<u> </u>
Maryland	a-f show		10a. State 10b. County		own or Location	e		10	d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the	e or 28 Lbe nul	Director	10e. Street and Number 8435 Harris Avenu		10f.	Zip Code 21 234		10g. Citizen of What Count USA	ry?
3-0030	jene. r than "natural", or items 23e or 28a-f show the Madical Examirer must be mulfied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1		cedent of Hispanic Origin? (specify Cuban, Mexican, Pue	Specify Yes or No into Rican, etc.)	14. Race - America Black, White, e	
Maryland 21215-0036	ie. Ian "natural Medical Ev	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation 1		work done during most of w Tuse retired)	orking	16b. Kind of Business/Ind	ustry
DG ZI	tal Hygien d other th event, the	Be Cor	12 17. Father's Name (First, Middle, Last)		Meat (18. Mother's N	11.	Food Servic	<u> </u>
aryia	and Mental is marked o	1º	James Guillott 19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing Addr		osephine Rural Route Numbe	HOLLOAY er, City or Town, State, Zip	Code)
o ?	lealth sm 27 ther to		Mrs. Dorothy E. Gr. 20a. Method of Disposition 1 Burial 2 Cremation 3 D	20b. Place	E435 Hai e of Disposition (etery, crematory	ris Ave. Pa Name of or other place)	rkville, Date	Maryland 212 20c. Location - City or Tox	
saitimore,	Department of Important: If Ite sny injury or or once.		*4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	Morel	22. Name		uck Towso	Baltimore, M	me, Inc.
	hysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	olications that caused the death. It one cause on each line.	Do not enter the r	mode of dying, such as card	ac or respiratory a	aryland 21204 rrest,	Approximate Interval Between Onset and Death
E	was persecuted by Medical transit tran	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	ARTER	y DISEASE	-		
O. Box oa	The law requires that the bean certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3 Ectopi	ic pregnancy (specify)		23d. Date of deliver Month	ry Day Year
ds, P.O.	n signed by	by	Part II. Dther significant conditions of	ontributing to death but not resulting	ng in the underlyin	ng cause given in Part I.		tobacco use contribute to th Yes 2 No 3 Proba	/
Records,		Completed					24a. Was auto perfo 1 Yes	psy prior to condemned death?	osy findings available appletion of cause of
Vita	certific rector.	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 ☐ EF	VOutpatient 3□	Othor	eath (Check only	one)	.)
Division of Vital	Attending Priys ir death. ector: After this by the funeral di	tion: To	27. Manne of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yeer) 28	8b. Time of Injury	28c. Injury at Work?		how injury occurred	/
Divis	그 하는 그	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At hombuilding, etc. (Specify)	e, farm, street, fa	ctory, office		Street and Number or Rural wn, State)	Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	edical (29a. Certifier Check only 2 Medical Example (Check only one)	ysician: To the best of my knowle niner: On the basis of examination and manner stated.	edge, death occur n and/or investiga	rred at the time, date and pla tion, in my opinion, death of	ce, and due to the curred at the time,	date and place, and due to	the cause(s)
)	To the within To the comp	M	29b. Signature and title of certifier	Makomen, r	(P	29c. License number D 0 0 5 8 5 0 9		29d. Date signed (Month, I	Dey, Year)
5	+1		30. Name and address of person who ZELALEM MAKONN	completed cause of death (Item 2	(3a) (Type, Print)	BLUD BALT	IMORE, A	ND 21239	
	St Regis	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signatur		rach			

			For State Registrar	State of	Marylan		artment of H		l Mental Hy	giene Reg. No. 20	04	18045
	Pĥysici	an	1. Decedent's Name (First, Middle Betty	, Last) Vill	iors				2. Date of De. Month June	ath Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution			ری	4b. City, Town, or	Location of De		4, 200		7:50 A. [™]
	LXdiiiii	içi	Gilchrist Cente	er			Tows	on		Balt	imor	e
	Funeral Director		5. Social Security Number 212-05-2954	6. Sex 1 ☐ M 2 X F	7. Age (In yrs. 87	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		, 1916	9. Birthp Cour Mary	place (State or Foreign ntry) Land
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					IOd. Inside City Limits
	Maryl f sho	tor	Maryland N/A	4	B	altimo	re					1X1Yes 2 □ No
	r 28e	Director	10e. Street and Number			<u> </u>	10f. Zip Code			10g. Citizen of V	What Cour	ntry?
	th wit		116 W. Univers	ity Parkwa	ay Apt	. 912		21210		U.S	S.A.	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 Is marked other then "neturel", or Items 23a or 28e-f show other treumatic event, the Medical Exertitive finant by modified at	by Funeral	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Dece Armed For ied 1 Tyes If Yes, Give Year or Da	ces? 2 <mark>M</mark> No ∍	Į.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? in, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	- 14. Rac Blac Specify	ck, White,	can Indian, etc. nite
9	2 hou		15. Decedent				dent's Usual Occupa		andrine	16b. Kind of Bu		
21215-0036	e filed within 7 al Hygiene. other then "n vent, the Med	Completed	(Specify only highes Elementary/Secondary (0-12) 12 years	College (1-	4or 5+)	life.	kind of work done of DO NOT use retired Supervisor)		Employme	ent S	Security
	be filed stal Hygi od other event, t	Be (17. Father's Name (First, Middle, I					18. Mother's N	ame (First, Middle,	Maiden Surnam	10)	•
Maryland	should Ind Menion Menio	2	Walter Villie			405 14-10	411 (0)	Jessic		Roseber		
Ma	d 2 sho th and t7 ls m treum		19a. Informant's Name/Relations Robert Willard	(nepher)		Fifth Ave		Rural Route Numbe			
ē,	ss 1 and 2 of Health item 27		20a. Method of Disposition	•	20b. F	lace of Dispo	SITULE AVE esition (Name of matory or other place		ew York,	20c. Location -		
altimore,	Page nent o int: If iry or		1 ☐ Burial 2 X Cremation `4 ☐ Donation 5 ☐ Other (S _i		iaie		unt Crema		-8-04	Baltim	ore.	Maryland
Balti	permit. Pages Department of HIMPortent: If ite any injury or of Once.		21. Signature of Funeral Service I	Licensee		22	Name and Address	s of Facility iedefel	d Funeral Baltimor	Home	Inc.	21212
			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on ea	ich line		er the mode of dyin	g, such as card	ac or respiratory ar			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a_ M	crus	HATIC	. Blade	der c	97002		,	Onset and Death
	/Medical Examiner		resulting in dealing	Due to (c	or as a conseq	uence of):						
		er	Sequentially list conditions, if any, leading to immediate	b. — Due to (d	or as a conseq	uence of):					-	
	licate be executed physician and s the burial-transit	Examin	Cause (Disease or injury that initiated events	d.								
Ö,	cate be executed physician and the burial-transit	I Exa	resulting in death) Last	Due to (d	or as a conseq	uence of):						
8760,	ate b ohysic the bi	dical		d								
.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		rth 2 ☐ Feta ant all time of d	Ideath 3	Ectopic pregnancy Other (specify)			23d. Dat Mor	te of delive	ory Day Year
Ω.		by Ph	Part II. Other significant condition	ns contributing to de	ath but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contr	ribute to th	ne cause of death?
rds	law requires as been sign 2 should be								1 □ Y	es 2 ☐ No	3 Prob	ably 4 Unknown
I Records,	The ate h page	Completed							24a. Was autop perfor	sy p mjed? d	Were autoporior to condeath?	psy findings available inpletion of cause of 2 No
Vital	Physicien: Th this certificate al director, pag	Be (25. Was case referred to medical examiner?	Manaital					eath (Check only o	ne)		1 8
of	S : 9	- T	1 ☐ Yes 2 No 27. Manner of D ath	Hospital: 1 ☐ In 28a. Date o		ER/Outpatier		4 Nursing	Home 5 Resid	ence 6 Nothe ow injury occurre	er <i>(Specify</i>	hospice
	Attending Ph r death. ector: Atter th by the funeral	tion	Natural 5 Pending	g (Month	, Day Year)	Injury	Work	rat (? Yes 2∐No	200. Describe II	ow injury occurr	ва	
Division	l or Atten after deatl Director:	ertification:	3 Suicide 6 Could r	not be 28e. Place	of Injury - At he	ome, farm, str	eet, factory, office				er or Rura	l Route Number,
ā	s after s after el Dire	Cert	4 Homicide	buildin	g, etc. (Specif	y)			City or Tow	n, State)		
	To the Hospitel or Attenwithin 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier Check only one)	g Physician: To the Examiner: On the ba and mann	sis of examina	wiedge, deati tion and/or in	n occurred at the tim vestigation, in my op	ne, date and pla pinion, death oc	ce, and due to the c curred at the time, c	ause(s) and mai date and place, a	nner as stand due to	ated. the cause(s)
)	To t With To I	Σ	29b. Signature and title of certifier	~~~			29c. License	303		29d. Date signed June 4		04 04
	6		101	who completed cause	0	23a) (Type,		3 SH F	saltimone	mo a	ماك	4
•	Sta Registi		31. Date filed (Month, Day, Year) JUN 0 8 2004	Seneral Seneral	egistrar's Signa		2 10 1					
					1	60	MAN					

		-	For State Registrar	State	of Mar	yland		artment rtificate			and M	ental Hyg	iene _{g. No.} 2 (004	18046
	Physicia		1. Decedent's Name (First, Middle Ida Marie									2. Date of Dea Month June		Oyear	3. Time of Death 7:35 a M
>	/Medic Examin	al .	4a. Facility Name (If not institution LongView Nursi	, give street and	nu <i>mber)</i>					Location o			4c. Count	y of Death Carro	11
	Funeral Director		5. Social Security Number 217–28–0883	6. Sex 1 ☐ M 2 🗹		(In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth July 2	, 1913	9. Birthr Cour Mary	place (State or Foreign Tand
	Maryland 1-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Carre	011	1		Mpstea							1	0d. Inside City Limits 1 ☐ Yes 2 🖾 No
	with the	Direc	10e. Street and Number 1413 N. Main &	št.				10f. Zip		21074		1	0g. Citizen of	What Cour	•
36	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23a or 28a-f show many injury or other traumatic event, the Modical Extrainer must be notified at ance.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mar 3 ☒ Widowed 4 □ Divorced	ied 1 7	Decedent Evit Forces? Ses 2 1 No. Give or Dates:			Was Deced If Yes, spec		ispanic Ori n, Mexicar Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		ce - Americack, White,	
Maryland 21215-0036	within 72 hou ane. than "natura na Mudical E	mpleted	15. Deceder (Specify only highe Elementary/Secondary (0-12)		ed) je (1-4or 5+))	(Give life.	dent's Usua kind of woi DO NOT us temake	rk done d se retired	during mos	t of work	ing	16b. Kind of E	Business/In	
land 2	uld be filed fentat Hygirked other	To Be Co	17. Father's Name (First, Middle, Thomas C. Tipt									(First, Middle, Naylor	Maiden Suma		344
Mary	nd 2 shouth and M		19a. Informant's Name/Relations Betty Lou Hale		ter			•				al Route Number Stead, N			Code)
Baltimore,	Peges 1 a nent of Hei int: If item iry or othe		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (5		om State	20b. P	lace of Dispo emetery, crei pstead	sition (Name matory or o	ne of ther place etery	y Jun			20c. Location Hamps t	-	
Balti	permit. Departrimports any inju		21. Signature of Funeral Service				32	chard 96 Ch	d Ad fo armi	inera 1 Dr	Cha Mar	apel P.A	, Md.	2112	
760,	Wedical Examiner	cal Examiner	23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. Due	on each line	consequ	uepge off	dhy	,					3	Interval Between Onset and Death 4444
.O. Box 68	The law requires that the death certificat the has been signed by the attending phy tage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No. 9 □ Unknown	1□Li 4□P	, outcome o ve birth 2 regnant at ti nknown	Feta	I death 3	⊒Ectopic pr ⊒ Other (sp						ate of deliver	ery Day Year
0	w requires that in the peak of	þ	Part II. Other significant conditi	ons contributing	to death but	t not resi	ulting in the u	inderlying o	ause giv	en in Part		23e. Did to	_	ntribute to t	he cause of death?
Il Records,		Completed										24a. Was a autop perfor 1 \(\text{Yes} \)	sy med?	Were auto prior to co death? 1 Yes	ppsy findings available mpletion of cause of 2 2 70
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			FD/0.4=44	200.00	Oth	DC:		n <i>(Check only or</i> me 5 ☐ Resid		thos (Canada	L.I
of	Jing After fune	ation; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendi 2 Accident invest	28a. C	I ☐ Inpatien Pate of Injury Month, Day		28b. Time of Injury		8c. injun			28d. Describe h			y)
Division	를 를 들	Certification;	3 Suicide 6 Could 4 Homicide deter	ained 286. h	lace of Injur uilding, etc.	ry - At ho (Specif	ome, farm, st	reet, factor	y, office			28f. Location (S City or Tow		nber or Rura	al Route Number,
	To the Hospital or within 24 hours after To the Funerel DIC completely filled in	Medical (29a. Certifier 1 Certifyi (Check only one) 2 Medica	ng Physician: To Examiner: On t and	the best of the basis of e manner stat	examina	wledge, deal	th occurred rvestigation	at the tin , in my o	ne, date ar pinion, de	nd place, ath occur	and due to the or red at the time, or	ause(s) and n late and place	nanner as s , and due t	tated. o the cause(s)
	To the within To the comp	M	29b. Signat and title of certifi	h .	11.4					e number	42		29d. Date sign	. /	* * * * * * * * * * * * * * * * * * * *
	7		30. Named ind address of person	who completed	cause of de	ath (Iten	. 0	, Print)	5	1	1	fing ste	الم	7 20	
	St Regist	ate rar	31. Date filed (Month, Day, Yea,	004	72. Registra	r's Signa			ER	d, l	NOS	m/9 5/2	er en l) 41	15/

			For State	tate of Maryland / Dep			0.001
			Registrar 1. Decedent's Name (First, Middle, Last)	CE	ertificate of Death	Reg. I	No.2 3. Time of Death
	Physici		Tall (-4	c t			5 2004 8:15 AM
>	/Medic Examin		4a. Facility Name (If not institution, give stre	et and number)	4b. City, Town, or Location of Dea		4c. County of Death
		•	Levindale Nu	irsing Home	baltimore		NIA
	Funeral		5. Social Security Number 6. Sex	2☐ F 7-Age (In yrs. last birthday Yrs.	Months Days Hours Min		9. Birthplace (State or Foreign
	Director		Usual Residence of Decedent	01		141.40,1	199 ITTUTY TUTTO
	aryland show	_	10a. State 10b. County	10c. City, Town or I			10d. Inside City Limits 1
	A Me	ecto	10e. Street and Number	Baltin	70re 10f. Zip Code	100	Citizen of What Country?
	Mith 1	Dir	2907 Grantley	AUD.	2/2/5		SA
	death	Funeral Director	11. Marital Status 12.	Was Decedent Ever in U.S. 13 Armed Forces?	. Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian, Black, White, etc.
98	or its	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give	1 ☐ Yes 2 ☐ No Specify:	10 (1001), 510.7	Specify: Black
21215-0036	72 hours atter death with the Maryland natural', or itams 23a or 28a-f show itsal Ezant'incroust be motified at	ed b	3 ☐ Midowed 4 ☐ Divorced 15. Decedent's Educat	Year or Dates:	edent's Usual Occupation	16b	Kind of Business/Industry
215	hin 72	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	ompleted) (Giv	re kind of work done during most of wo DO NOT use retired)	orking	P.L.
	ygiene ygiene yer the	Сош	12th	Uti	lity Worker	(114
and	be fill ad off	Be	17. Father's Name (First, Middle, Last)		18. Mother's Na	ıme (First, Middle, Maid	len Sumame)
Maryland	is 1 and 2 should be filed within 72 hours atter death with the Marylan of Health and Mental Hygiene. itam 27 is markad other than "natural", or Itams 23a or 28a-f show itam 27 is markad other than "natural", or Itams 23a or 28a-f show other traumatic evant. The Madical Exartana traumatic evant.	5	JONN Ghee 19a. Informant's Name/Relationship (Type,	Print) 19b. Mai	iling Address (Street and Number or F	Rural Route Number, Cit	y or Town, State, Zip Code)
	aith ar 27 is ar trau		Beverly Sims-day	19hter 2908	3 Grantley Ave.	Balta, mi	21215
ore,	of Health of Health if itam 27 i		20a. Method of Disposition 1 Burial 2 Fremation 3 Rem	20b. Place of Disposal from State	position (Name of ematory or other place)		Location - City or Town, State
Baltimore,	mit. Pag bartment bortant: 1 injury o		* 4 □ Donation 5 □ Other (Specify)	1 Metro	rematory 6	7-04 Ca	itonsville, MD
Baj	permit. Pages Department of Important: If i any injury or once.		21. Signature of the eral Service Licenson		22. Name and Addr ss of Facility	in Frank: Ihr	Ass Balto, mo 21229
			23a. Part Eper ne disease, or complicat shock, or part failure. List only one	ions that caused the death. Do not e	nter the mode of dying, such as cardia		Approximate Interval Between
	Physician		Immediate a se (Final disease or Indition	ESOPHAGEA	L CANCER		Onset and Death
7	/Medical Examiner		resulting in death)	Due to (or as a consequence of):			
	- ·	ē	Sequentially list conditions, b	Due to (or as a consequence of):			
/ _	uted 1 ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c				
o,	be executed ician and burial-transit		resulting in death) Last	Due to (or as a consequence of):			
8760	ate thys	dicai	d				
9 X	The law requires that the death certificate has been signed by the attending places as should be detached for use as t	/Me	IF FEMALE: 23c.	If yes, outcome of pregnancy			23d. Date of delivery
Box.	death a atter d for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	4☐Pregnant at time of death 5	□ Ectopic pregnancy □ Other (specify)		Month Day Year
P.0	by the	hys	9 Unknown	9□ Unknown			
	ires tha signed I I be det	b	Part II. Other significant conditions contri	buting to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death? 2 □ No 3 No 2 □ Probably 4 □ Unknown
orc	w requir been si should	eted				24a. Was an	
Rec	The law ate has I page 2 s	ompleted				autopsy performed	
Vital Records,		e C	25. Was case referred to medical		26. Place of De	1 ☐ Yes 2 X eath (Check only one)	No 1 ☐ Yes 2 No
of V	hysician: this certitic	To B	TI THE ZENO	pital: 1 ☐ Inpatient 2 ☐ ER/Outpati		Home 5 ☐ Residence	6 □Other (Specify)
o u	ding Ph h. After th funeral	ion:	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how in	njury occurred
Division	death. ctor: A y the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm,			and Number or Rural Route Number,
Div	al or A	Serti	4 Homicide determined	building, etc. (Specify)		City or Town, St	ate)
	Hospital or Attanding Physician: 24 hours after death. Funaral Director: After this certition tely filled in by the funeral director,	edical (ian: To the best of my knowledge, der : On the basis of examination and/or			
	To the Hospital or Attanowithin 24 hours after death To tha Funaral Director:	Medi	one) 29b, Signature and title of certifier	and manner stated.	29c. License number		Date signed (Month, Day, Year)
	T will		All all and the second	the -	D23767		
	rb		30. Name and address of person who com	pleted cause of death (Item 23a) (Type	e. Print)	2	140. PH 21215
_			Delora/WerTheir	ner 10 2439	W Beheder 1.	ve, Bu	to. 1H 21215
	St Regist	ate	31. Date filed (Month, Day, Year) JUN 0 8 2004	32. Registrar's Signature	1		
	. negisi	TGI		1	works		

			For		Marylan				ealth a	and M	ental Hyg	iene	9	
		-	For State Registrar			Ce	rtificate	e of L	Death			eg. No. 2	004	18048
	Physicia		Decedent's Name (First, Middle MT	e, Last) RIAM			G	ILBE	RT		JUNE 5	_	Year	3. Time of Death 5:15 P M
	/Medic Examin	al .	4a. Facility Name (If not institution		ber)				Location of	of Death		1	inty of Death	
	Examin	eı	4000 N. CHARL							LIMOL				N/A
	Funeral		5. Social Security Number 063-16-8341	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. 8		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth Month, Day	, 1918	9. Birth Coi	nplace (State or Foreign Unitry) N.Y.
	Director		Usual Residence of Decedent				1							10d Incide City Limits
	anylan show	5	10a. State 10b. County	Λ	10c. Cit	y,Town or Lo	IMORE							10d. Inside City Limits 1 Yes 2 No
	the M	Director	MD N/	A		DALI	10f. Zip					l0g. Citizen	of What Co	untry?
	h with 23a or	ai Di	4000 N. CHARL	ES STREET	#801				212					U.S.A.
	r deat	Funeral	11. Marital Status	12. Was Dece Armed For	dent Ever in U	.S. 13.	Was Deced If Yes, spec	dent of Hi cify Cuba	ispanic Ori n, Mexicar	gin? (Spe n, Puerto	ecity Yes or No- Rican, etc.)		Race - Ame Black, White	
36	72 hours after death with the Marylan "naturel", or itams 23a or 28a-f show witeal Examinat must be multiled at	by	1 ☐ Never Married 2 ☐ Mar 3 🛱 Widowed 4 ☐ Divorced	If Voc City	е .		1 ☐ Yes	2 X No	Specify:			Spi	ec <i>ify:</i>	WHITE
2-0	72 hou	eted		t's Education st grade completed)		(Give	dent's Usua kind of wo	rk done d	<i>during</i> mos	t of work	ing	16b. Kind	of Business/	Industry
121	within	Completed	Elementary/Secondary (0-12)	College (1	-4or5+)		DO NOT U		,			OWN H	IOME	
d 2		Be Co	17. Father's Name (First, Middle,	Last)							e (First, Middle,	Maiden Sur		VI F1/
Maryland 21215-0036		ToE	SAMUEL				COWITZ	!		LLIA	al Route Numbe	. City or To		YLEK Zin Codel
Mar	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relations LESLIE SLAN /								VE - RO			
	ges 1 an t of Heal if item 2 or other		20a. Method of Disposition			Place of Disp cemetery, cre	osition (Na	ne of			Date		on - City or	
imo	Pages ment of ent: If it ury or o		1 🛱 Burial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (\$	Specify)	BAL	TIMORE								WN, MD
Baltimore,	parmit. Pages Department of Importent: If it eny injury or o		21. Signature of Sameral Service	Literisa	a na						L LEVINS ROAD - I			, INC. MD 21208
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that	aused the dea									Approximate Interval Between
J.	Priysician		Immediate Cause (Final disease or condition		·sma									Onset and Death
ı	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):)						O
		je.	Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury	b. Due to	or as a consec	quence of):								
	and transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consec	ruence of):								
760,	requires that the death certificate ba executed een signed by the attending physician and hould be detached for use as the burial-transit	cal E		d	(O) 83 8 0011301	4441100 01).								
89	tificate ng phys		IS SSAME.	0										
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o.	the de y the a	ysic	1 ☐ Yes 2 🕅 No 9 ☐ Unknown	9□ Unkn		ueatii J								
4	w requires that the de been signed by the should be detached	by PI	Part II. Other significant condit	ions contributing to d	eath but not re	sulting in the	underlying	cause giv	en in Part	l.				the cause of death?
ord	een si	eted									1 🗆 \			
Records,	S S S	Completed										rmed?	prior to death?	utopsy findings available completion of cause of
Vital	(0 -	0	25. Was case referred to medic	al					26. Plac	e of Deat	1 ☐ Yes	2 X No	1 🗆 1 65	20110
of Vi	A S P	To B	examiner? 1 ☐ Yes 2 🂢 No			ER/Outpatie		UA		ursing Ho	ome 5 X Resid			cify)
o uc	ling After fune		27. Manner of Death 1 Natural 5 □ Pend	ing 28a. Date (Mon tigation	of Injury th, Day Year)	28b. Time Injury	of M	28c. Inju Woi 1 □	ryat rk? ∣Yes 2.⊑]No	28d. Describe	iow injury o	ccurred	
Division	Attending r death. ector: After by the fune	Certification;	3 ☐ Suicide 6 ☐ Could	not be 28e, Place	of Injury - At I	home, farm, s	treet, factor	y, office		1	28f. Location (: City or Tox		lumber or Ri	ural Route Number,
Ö	rs after el Directed led in by	Cert												
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical	29a. Certifier 1 X Certify (Check only 2 Medical	ing Physician: To the back that the back and man	e best of my kr easis of examin liner stated.	nowledge, dea nation and/or i	th occurred nvestigation	d at the ti n, in my o	me, date a opinion, de	nd place, ath occur	and due to the red at the time,	cause(s) an date and pla	d manner as ace, and due	s stated. e to the cause(s)
	To the within ?	Mec	29b. Signature and title of centif				29	c. Licens	se number	_		29d. Date s	igned (Mont	th, Day, Year)
	1		I LIFE	45				PI	647	1		6/6	104	
	15		30. Name and address of pers	1/		om 23a) (Typo (EENE)		Qa	1400	0000	MD 3	1201		
	S	tate	31. Date filed (Month, Day, Yes	- 1/	Registrar's Sign			υα	CLIVI	wit,	1000			
	Regis		JUN 0 8 21	104 Ben	war	19	Spar	W				_		-

DHMH 17 Rev 1/2001

ORIGINAL

			1- State of Maryland / De State of Maryland / De State	epartment of Health and Me Certificate of Death	ental Hygier	
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Yeer 3. Time of Death
	Physicia /Medic		Leonard Marvin Hanson	Jr.	June 04	
>	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	4c. County of Death
			328 Oakdale Road	Pasadena		Anne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthe	Months Days Hours Min. _	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director	}	215-07-0700 15AW 21F 83 Yr Usual Residence of Decedent	s	June 16	1920 MD
	and and		10a. State 10b. County 10c. City, Town of	or Location		10d. Inside City Limits
	Mary -f sh	ō	Maryland Anne Arundel	Pasadena		1 ☐ Yes 2 ☐XNo
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
	h with		328 Oakdale Road	21122		USA
	dear	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto R 	cify Yes or No-	14. Race - Americen Indian, Black, White, etc.
36	be filed within 72 hours after death with the Maryland and Hylyliene. All Hylyliene dictine then "naturel", or items 23a or 28a-f show do dither then "naturel", or items 23a or 28a-f show event, the Medical Examinal must be notified at		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☒ No Specify:		Specify: White
ö	hours turef	d by	3 ⊠ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. □	ecedent's Usual Occupation	16h	Kind of Business/Industry
Ϋ́	in 72 "nai	Completed	(Specify only highest grade completed)	Give kind of work done during most of working. The state of the state	g 100.	Trind or business/industry
72	iene.	E o	Elementary/Secondary (0-12) College (1-4or 5+)	Steamfitter		Local Union
ਰੂ	e filed I Hyg othe	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	en Sumame)
<u>lar</u>	should by	ToE	Leonard M. Hanson Sr.	May	Wallis	
an	2 sho and I Is me			Mailing Address (Street and Number or Rural		
Baltimore, Maryland 21215-0036	and lealth m 27 her tr		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	28 Oakdale Road, Pasa		
0	Pages 1 nent of H ant: If itel ury or oth		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery,	crematory or other place)	09	Location - City or Town, State
ij	t. Pa rtmen rtent: njury			od Cemetery 200)4 Ba	ltimore, Maryland
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If time 27 is marked other then "naturel; or tlems 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		21. Signature of Funeral Service Licental	3111 Mountain Road		Funeral Home, P.A.
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardiac or	respiratory arrest,	Approximate
3	Dhusisian		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	erotic Heart	-	Interval Between Onset and Death
2	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of		1)158	454
	Examiner		Diabete	9		
_	p =	iner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
0	ecute and trans	Examiner	Cause (Disease or injury that initiated events c			
8760	cate be executed physician and the burial-transit	alE	Due to (or as a consequence of	•		
687	physicate s the	Physician/Medical	d			
Box (eath certific attending p	J/M	IF FEMALE: 23b. Was decedent pregnant			23d. Date of delivery
	The law requires that the death certific ate has been signed by the attending p age 2 should be detached for use as:	Iclai	in the past 12 months? 1 Vas. 3 No. 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
P.O.	t the by the tache	hys	9 ☐ Unknown			
	signed d be de	by P	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.		o use contribute to the cause of death?
ord	n require been si should I	ted	Alizheimer's Disense		1 Tes	2 No 3 Probably 4 Nonknown
ecc	e law r has be je 2 sh	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
of Vital Records,	: The	Con			performed? 1 ☐ Yes 2 ☐	
Zita Zita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	- 32	
oţ	Phys r this rral di	2	1 Dayes 2 No No Note 1 Inpatient 2 ER/Outp 27. Manner of Death 28a. Date of Injury (Month, Day Year) Inj 1 Manual 5 Pending (Month, Day Year)	atient 3 DOA 4 Thorsing Holl	8d. Describe how in	6 ☐Other (Specify)
on	Attending r death. sctor: After by the fune	atlor	1 ANatural 5 Pending (Month, Day Year) Inj 2 Accident investigation	ury Work? M 1 ☐ Yes 2 ☐ No		
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	rs after al Dire	Cert	Sulating, etc. (appear))			
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier (Check only (Check only Medicel Examiner: On the basis of examination and/			
	To the I within 2. To the I complet	Med	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, Day, Year)
	F 3 F 8		1/1/10 Pa	D 0605	4	6/7/04
	10		30. Name and address of person who copped cause of death (Item 23a) (T	ype, Print)	,	
	10		William P. Jones, mi	0 695 ftm	erica	21035
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	it species		
	Registi	ar	JUN 0 8 2001 Steelie	AT PROPERTY		

		-	State of Maryland / Department of Health and M State of Maryland / Department of Health and M State of Maryland / Department of Health and M Certificate of Death	lental Hyg	giene leg. No. 200	4 18050
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) ALICE HARRINGTON	2. Date of Dea Month DS	Day Year	3. Time of Death 3.45 A M
1	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death COLLIMBIA		4c. County of Dea	ARD
	Funeral Director		5. Social Security Number 6. Sex 1	8. Date of Birth (Month, Day DS/14	(Year) C	rthplace (State or Foreign ountry)
	Maryland a-f show	tor	10a. State 10b. County 10c. City, Town or Location COUMBIA			10d. Inside City Limits 1 ☐ Yes 2 ⊠No
	ath with the Marylan 23a or 28a-f show ust be notified at	al Director	10e. Street and Number 10f. Zip Code 21045		10g. Citizen of What C	
5-0036	after deg	by Funerai	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes, 2 StNo If Yes, specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	te, etc.
21215-0	id within 72 hours giene. er then "naturel", Ine Modical Ere,	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 1	ng	16b. Kind of Business COSME	Widgy 1 cties
Maryland 2121	12 should be filed within h and Mental Hygiene. 7 Is marked other then " fraumatic event, It e Mar	To Be (. Mae	. stever	
	ges 1 and 2 should t of Health and Mer If item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type, Print) Nathaniel Harnington 20b. Place of Disposition 19b. Mailing Address (Street and Number or Rura 359 E. DCEAN AVE	LAN	r, City or Town, State, T:ANA FUC 20c. Location - City o	R104 33462
Baltimore,	Pages ment of ent: If it ury or c		1 XBurial 2 □ Cremation 3 □ Removal from State 1 XBurial 2 □ Cremation 3 □ Removal from State 1 XBurial 2 □ Cremation 3 □ Removal from State 1 XBurial 2 □ Cremation 3 □ Removal from State 1 XBurial 2 □ Cremation 3 □ Removal from State 1 XBurial 2 □ Cremation 3 □ Removal from State 1 XBurial 2 □ Cremation 3 □ Removal from State	4/04	Annapa	olis, MD
Ba	permit. Departi Import any inj	Ī	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	JAL PIKE	BALTHUDE	Approximate
	Pn ysicia n /Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):			Interval Between Onset and Death
	Examiner	Jer.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Law Many H IV	dise	íl	
8760	ate be executed hysician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C.			
.O. Box 6	The law requires that the death certific te has been signed by the attending pi tage 2 should be detached for use as i	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of de Month	olivery Day Year
<u>α</u>	n requires that been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute t es 2 □ No 3 □ P	o the cause of death?
Vital Records,		Completed		24a. Was a autops perform	sy prior to med2 death?	utopsy findings available completion of cause of
Vita	sicien: T certifical irector, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 3 No			
on of	or Attending Physicien: after death. Director: After this certific in by the funeral director.	ition: To			ence 6 Other (Spe ow injury occurred	ecity)
Division	el or Attendi s after death.	Certification:	3 Districted 6 Discould not be	28f. Location (S City or Town	treet and Number or Fi n, State)	ural Route Number,
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	edical	29a Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a control of the control of	and due to the c ed at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	To t Com	Σ	29b. Signature and title of certifier 29c. License number 1.70501		6/3/0 4	
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dh Torchh Penlow 4994 Behvenhanch 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Rd	Columbia.	mo 21044
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 200 William Robert Hamann, Sr. 7.50AM /Medical 4a. Fecility Name (If not institution, give street and number) County of Death 4b. City, Town, or Location of Death **Examiner** FRANKL 10 20 moi 6. S(x) 1 XM 2□ F If Under 24 Hrs. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Hours 218-18-6614 Director 79 08/11/1924 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at by Funeral Director BAltimore 1 ☐ Yes 2X No Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6901 Mt. Vista Road 21087 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction INspector Housing Authority 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental F Pages 1 and 2 should be William M. Hamann Ida Hartung 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is eny injury or other trau once. 75 Seagull Road - Selbyville, Delaware 199 Date 20c. Location - City or Town, State Kathleen Michalisin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial Park 06/05/04 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. as 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Dug to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a conse (uence of): physician P.O. Box 68760 Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Hes 2 No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed 2 10 Hospital or Attending Physicien: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 32 DOA Certification: To 1 ☐ Yes 2 ☑ 1√0 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 ENatural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funerel Director: A 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the

State Registrar

31. Date filed (Month, Day, Year) JUN 0 8 2004

29b. Signature and title of certified

6530 WAL 32.*Registrar's Signature

D(I)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

1002 769

restove Baltimore

29d, Date signed (Month, Dav. Year)

		1- For State of Maryla	•			ental Hy	giene 200	4 18052
		Registrar 1. Decedent's Name (First, Middle, Last)			Jun 1	2. Date of Dea		3. Time of Death
Physi	ician	JOAN WALKER HOBACK				Month MAY	Day Yea	ir .
	dicat	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L	ocation of Death	MAI	31, 200 4c. County of De	
Exam	niner		т.					
		MARINER HEALTH OF FOREST HIL 5. Social Security Number 6. Sex 7. Age (In y	பட் vrs. last birthday)	FOREST	HILL If Under 24 Hrs.	8. Date of Birtl		FORD Birthplece (State or Foreign
Funera Directo		224 25 3252 10M 28F 96	Yrs.		Hours Min.	8. Date of Birth (Month, De)	1907 Ps	Birthpleca (State or Foreign Country)
	^	Usual Residence of Decedent				1104-14	1901 112	ALLANDEN ALLAND
yland		10a. State 10b. County 10c.	City, Town or Lo	ocation				10d. Inside City Limits
Man.	ģ	Marsians HARFORD	FALLS	0072				1 ☐ Yes 2 1 No
r 282	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?
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deati	Funerai	11. Marital Status 12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spe	city Yes or No-	14. Race - Ar	mencan Indian,
after or lite		1 Never Married 2 Married 1 Yes 254 No		_	Specify:	nican, etc.)		nite, etc.
3 ones	b	3 Widowed 4 □ Divorced Year or Dates:		10 165 2,56 110	эрвену.		Specify:	271/6
72 h	etec	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupation in the design of th	on ring most of workii	na	16b. Kind of Busines	ss/Industry
L is is	id	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retired)			0 00	0.5000
yidilid. Z. i.Z. i.D. 00000 build be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Items 23a or 28a-f show atte event, the Medical Exertinet and the notified at	Completed	19788-		ZZZSTÍA			BELMAR	DAKE.KY
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should nd Men marke	မ	HARVEY WALKER			Alrica	Di	121-13-134	*
2 sho and ls m		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ing Address (Street an	d Number or Rura	l Route Numbe	r, City or Town, State	Zip Code) 31047
is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. It is a marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Extra where and the notified at		KUTH V. PEARY	3012	ROUNDIL	X1000	151131	EU LIAM	AAO
ages 1 If itel		20a. Method of Disposition 20b Surial 2 ☐ Cremation 3 ☐ Removal from State	b. Place of Dispo cometery, cre	osition (Name of nmatory or other place)	JUNE	ate	20c. Licention - City	or Town, State
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Dattill permit. Pa Departmer Important	9	21. Signature of Funeral Service Licensee	53:	2. Name and Address	of Facility	TEMBR	2312	21234
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/Medica		resulting in death)	sequence of):	V 3 DXI	HEATT	\		ten years
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The Colds, F.O. BOX 60 The faw requires that the death certifical te has been signed by the attending phy page 2 should be detached for use as th	Jed	Lessons .						
th cert	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ F		☐Ectopic pregnancy			23d. Date of c	,
death death	ici	1 Yes 25 No 4 Pregnant at time of		Other (specify)			Month	Day Year
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The ! The ! te ha	Completed		111111111111111111111111111111111111111	,,,,		autop: perfor	med? death	?
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g Phy or this	n L	27. Mann of Death 28a. Date of Injury (Month, Day Year	28b. Time o	of 28c. Injury a Work?			ow injury occurred	
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or Attending after death. Director: Afte	110	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Spe	t home, farm, st	reet, factory, office	2	8f. Location (S City or Tow	treet and Number or	Rural Route Number,
s after	Certification:	building, stc. (a)	berry)			Only of 10W	n, State)	
bspit hour ners		29a. Certifier 1 Certifying Physician: To the best of my	knowledge, deat	th occurred at the time,	date and place, a	and due to the o	ause(s) and manner	as stated.
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	Medical	(Check only one) Medical Exeminer: On the basis of exam and manner stated.	iliation and/or in	ivestigation, in my opin	non, death occurre	eu at the time, o	uate and place, and d	ue to the cause(s)
To t. withi To tl	Z	29b. Signature and title of certifier		29c. License r	number	2	29d. Date signed (Mo.	nth, Dey, Year)
		1 LIM / n	10	Die	1583	1	une 2,2	OOU
`	9	30. Name and address of person was completed cause of death (i	item 23a) (Type	, Print)		14		W Y
		DR. MANUEL LAZATIN - 8 LAW S	TREET -	ABERDEEN,	MD. 21	001		
	State	31. Date filed (Month, Day, Year) 32. Registrar's Si	gnature	Sporks				
Regi	strar	JUN 0 8 2004	No.	popour				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM #5 PER FII G832te 6/29 A Department of Health and Mental Hygiene 1- StateAmend Item#13, per FH,G832,6/8 Centificate of Death Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 06/03/2004 10:20AM Mae Hirshauer /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e. Facility Name (If not institution, give street and number) Examiner Anne Arundel Pasadena Cache House Assisted Living tf Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. 212-36-2550 **Funeral** Months 1 ☐ M 2 🏗 F Director 36-2550 08/06/1922 MD 81 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County in then "natural", or Items 23a or 28a-f ehow the Medical Exemprer must be notified at 1 Yes 2 No Pasadena Anne Arundel Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 8088 Ventnor Road 21122 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Tes 2X No Specify. þ 3 Widowed 4 □ Divorced White Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Antique Shop 12 Proprietor permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked othe eny injury or other transment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary V. McComas Thomas Chilcoate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8104 Frances Lane, Gilbert A. Hirshauer/Son Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) Glen Haven Mem Pk 06/07/04 Glen Burnie, MD 22. Name and Address of Facility G.J.Gonce Funeral Home, 21. Signature of Funerat Service Licensee 169 Riviera Dr., Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final disease or condition resulting in death) TRO Physician 91 /Medical Examiner Sequentially list conditions, flavour list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 10 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 2 ☐No 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? death?
1 ☐ Yes 2 ☐ No. 1 Yes 21 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitat: 1 ☐ tnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 DN6 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident 6 Could not be determined

Box 68760 Division of Vital Records,

burial-transit the attending physician detached for signed by peeu Hospitel or Attending Physician: death. s after death 24 hours a

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Baltimore, Maryland 21215-0036

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within 2 To the I t) e

> State Registrar

Medical

3 Suicide

29a. Certifier

4 Homicide

11 entitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of certifier M

29c. License number

29d. Date signed (Month, Day, Year) 04

28f. Location (Street and Number or Rural Route Number, City or Town, State)

who completed cause of death (Item 23a) ype, Print) 30. Name.

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Ptace of tnjury - At home, farm, street, factory, office building, etc. (Specify)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

	Ar	nen	d Item #17, per FH	, G832, 6/	8/2004,	repartment of Certificate of	nealth and i Death	wentai myg R	ea. No. 20	04 18054
	Physic		1. Decedent's Name (First, Middle, La		1	4 5		2. Date of Deat Month		3. Time of Death
M.	/Medi	cal	KOSE 4a Facility Name (II not institution, giv	HN street and aumber	N	HAM	4b. City, Town, or	JUNE	0.5 4c. County	2004 9:30 814
1	Examir	ner	F - 7.	E NURSI	1 1	OME	n	RSTOWN	/3	AI TIMORE
	Funeral		5. Social Security Number 6. S		ge (In yrs. last birt	Months Days	r If Under 24 Hrs	8. Date of Birth	Year)	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		75	rs.		MAY16	,1929	VIRGINIA
	ryland thow	_	10a. State 10b. County		10c. City, Town	0		1		10d. Inside City Limits
:	Ne Me	octo		THORE		KEIST	ERSTO			1 ☐ Yes 2万No
	effer deeth with the Marylar or Items 23s or 28s-f show miner must be notified at	Funeral Director	10a. Street and Number	STERSTO	WN ROA	10f. Zip Code	2113	/- "	0g. Citizen of V	vnat Country?
3	deeth	nera	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (S	pecify Yes or No-		e - American Indian, ck, White, etc.
20	s effe	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 K If Yes, Give Year or Dates:		1 ☐ Yes 2 ØNo			Specify	
5-0020	within 72 hours effer deeth with the Maryland ene. Han "naturel", or items 23s or 28s-(show he Madical Examinar must be notified at	ted t	15. Decedent's Ed	ducation	16a.	Decedent's Usual Occu	pation		16b. Kind of Bu	USLACK usiness/Industry
21218	and	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or	5+)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	e dunng most of wolled)	rking	14.	0
0	Hygler than the training of training of the training of tr	S	8 FMG-RADE. 17. Father's Name (First, Middle, Last)	Steven		ETARYS	18. Mother's Nar	SOR me (First, Middle, N	Maiden Sumam	PITAL
an	should be filed within and Mentel Hyglene. marked other than imatic event, the Mentel Hyglene.	To Be	STEPHEN	breven	TRAV	HAM	MART	4 -	M	URPHU
Mary	emit. Pages 1 end 2 should be filed within Department of Heelth end Mentel Hyglene. Important: If tem 27 is marked other than eny injury or other treumatic event, the Manage.	-	19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Stree			City or Town,	State, Zip Code)
	1 end Heelth FM 27 ther tr		LEONARD HA 20a. Method of Disposition	M (S	20h Place of	O / S MAL Disposition (Name of	ISON A	VE. BAL	LT/HOA	City Town, State
Baltlmore	ant of ht: If it		1/8 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		cometan	, crematory or other pla	ace)	11-11-14	A core ale	ac Mille MA
att	permit. Pa Departmen Important: eny injury ence.		21. Signature of Funeral Service Licer		OHER	22. Name and Addr	ess of Facility	20411	R Fun	ERAL HOME
Ω :	82558		Weetich	N. Wil	leams	2140 N	FULTO,	JAVE &	BALTO,	
			23a. Pert1. Enter the disease, or com shock, or heart failure. List only	ptications that cause one cause on each li	d the death. Do n ne.	ot enter the mode of dy	ing, such as cardiad	or respiratory/arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final	ATHE	ROSCL	EROTIC	CER	EBRO (1Asu	LAR DISEASE
E	Examiner		disease or condition resulting in death)	e/	Due to (or as a c				194	
	nsit	Examiner	_	b						
o,	Tificate be executed grown physicien and as the burlat-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as a co	onsequence of):				
68760,	physici s the bu	edical	that initiated events resulting in death) Last	C	Due to (or as a co	onsequence of):				
			L	d				***************************************		
Box	requires thet the deeth cert seen signed by the attendin hould be detached for use	Physician/N	Part II. Other significant conditions of	ontributing to death b	ut not resulting in	the underlying cause gi	iven in Part t.	23b. Did tol	bacco use cor	tribute to the cause of death?
P.0	d by the	Phy						1 □ Ye	s 2 No	3 Probably 4 Onknown
ds,	signe d be d	d by						24a. Was ar	n autopsv	24b. Were autopsy findings
of Vital Records,	w require s been si	Completed	_					perform	ned?	available prior to completion of cause of death?
I R	ne lew sete hes b page 2 s	E						1 □ Ye	s 212 No	1 □ Yes ₽ No
Vita	r this certificete	B	25. Was case referred to medical examiner?	Hospital:		Or	26. Place of Dea	ath (Check only one	9)	
ō	ray this seld of	2: 10	1 ☐ Yes 2 ☑ No 27. Manager of Death	1 ∐ Inpatie	ry 28b. Ti	me of 28c. Inju	4 Nursing H	ome 5 ☐ Resider 28d. Describe hor		
nois	Attending Pri	atlo	Natural 5 ☐ Pending investigation		y Year) In		ork?]Yes 2□No			
	after deeth. Director: Af	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of tnj building, et	ury - At home, fan c. (Specify)	n, street, factory, office		28f. Location (Str City or Town,		er or Rural Route Number,
	vithin 24 hours after deeth. To the Funerel Director: A completely filled in by the fe		29a. Certifier 1 Certifying Ph	ysician: To the best	of my knowledge,	death occurred at the ti	ime, date and place	, and due to the ca	use(s) and ma	nner as stated.
1.5	the Fu the Fu	Medical	one)	niner: On the basis of and manner sta	examination and ated.					and due to the cause(s)
	- F F		29b. Signature and little of certifier		0.1	29c. Licen:	se number	29	d. Date signed	(Month, Day, Year)
	2 ₹ 2 §		10	No.	10000	7 1	120050		6/7/4	7 .
	\$ \$ \$ \$		30. Name and address of person who	Completed cause of d	eath (Item 23a)	ype, Print)	128595		6/7/0	4
	2 \$ 2 8	4	30. Name and address of person who of TASNEEM	CARHA	eath (Item 23a) (T	Type, Print) 1220 PA	RK Ha	EICHTS	6/7/0 AVE	BAUDLU

DHMH-16 Rev 1/89

ed by the hospital or attending physician.	irector, page 5 should be detached for use as the burial-transit permit	ed at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 sho Is a find within 22 bours after death with the Crass Deut of Health and Mental Huripon infort to build cremation or removal	or men its mous and ocan win the class popular in the medical process of consistent of the medical examiner must be notified. IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified.

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876

1. DECEDENT'S NAME (FIRST,	Middle, Last)	4	4	,			2. DATE C	F DEATH D	ΑY	YEAR 3	. TIME OF DEATH	
ANN	1E	N	1ATC	H			6	4	4 20		4:20	Fin
4. SOCIAL SECURITY NUMBI			. AGE (In yrs. las	MC	ONTHS DAYS	HOURS MIN.	7. DATE O	F BIRTH /	0.42	Country)	ACE (State or Fore	ign
217-40-770	0	1 M 2 F	61	YRS.				0,1	41	aryl		
9a. FACILITY NAME (If not ins				9		or location of di imore	EATH			Y OF DEA	TH	
Bon Secou	r HOS]	oitai			вать.	Inore				,		
10a. STATE	10b. COUNTY			10c. CITY, 1	TOWN OR LOCA	ATION				10	Od. INSIDE CITY	
Maryland	Balt:	imore		Ba	altimo	ore				x	YES 2 N	10
			A	nt 30	0.4	Of. ZIP CODE			10g. CITIZ	EN OF WH	AT COUNTRY?	
5110 Balt	imore	Nation	al Pik	E		21229			U	SA		
11. MARITAL STATUS		12. WAS DECEDENT I FORCES? 1	EVER IN U.S. AR	IMED NO		CENDENT OF HISPA pecify Cuben, Mexic			a or No—	14. RACE - Black, \	- Amaricen Indler Whita, atc.	3,
1 X Never Merried 2 U I 3 Widowed 4 Divor		IF YES, GIVE WAR	OR DATES		1 🗆 YE	S 2 NO Speci		, 5,5,7		Specify:	Black	ς
	EDENT'S EDUCA	TION	T 460 DE	CEDENT'S US	UAL OCCUPAT	701	465	VIND OF BU	ISINESS/INDU	ICTDV		
(Specify only	highest grade co	ompleted)	(G	ive kind of work Do NOT use r	k done during n	nost of working	Soc	cial	Secu	rity	7	
Elementary/Secondary (0-		Years		1 Cl					strat			
17. FATHER'S NAME (First, Mil		rears	riai		C 1 7 1	18. MOTHER'S NA	AME (First, M	iddle. Maider	Sumema)			-
Preston B.		h				Doris			,			
19a. INFORMANT'S NAME (Ty		11	19	6. MAILING AL	DDRESS (Street	and Number or Rural	Route Numbe	er, City or Toy	wn, State, Zip	Code)		$\overline{}$
Shawn Hato		n	31	Als	ab Co	urt Bal	timo:	re, I	Maryl	and	21244	
20a. METHOD OF DISPOSITI	ON		20b. PLACE		DISPOSITION (9	OCATION — C			\neg
1 Donation 5 Other	n 3 🗆 Ramov (Specify)	/al from State	Greatery, cre	matory or othe	r place)	etery	6/8	/ 04 1	Balti	more	e, Mar	ylan
21. SIGNATURE OF FUNERAL	SERVICE VICE	NSEE	IGI EE	IIIIOUII	22. NAME	AND ADDRESS OF FA						
S.	4					,5240 R			own F	Rd Ba	altimo:	
23. PARTA Enter the di	Mrs	mplications that	caused the de	ath Do not	anter the m	and of dular au	ah aa aasdi	00.01.500		2121	Approxima	
iMMEDIATE CAUSE (Fin disease or condition resulting in death)		A CU			OCA	RDIAL	_ /n	IFA.	RCTI	ואה	Interval Be Onaet and	Death
Sequentially list condition if any, leading to immediate. Enter UNDERLY!! CAUSE (Disease or injust that initiated events resulting in death) LAST	diate NG ry c.		OR AS A CONSE									
	d.										+	
PART II. Other aignifican		ASCUL		_			Part i.	PERFO	RMED?	1 6	VERE AUTOPSY FIN AVAILABLE PRIOR 1 COMPLETION OF CA OF DEATH?	ro l
CANCE		OF TH			YN				-	1	YES 2 N	ю
DID TOBACCO U	SE CONTR	IBUTE TO CAU	SE OF DEA	ATH YES	□ NO I	UNCERTA	IN 🗆					
25. WAS CASE REFERRED TO EXAMINER?		HOSBITAL	26. PLA		(Check only on	θ)						
1 TES 2 NO		HOSPITAL:	ER/Outpatient 3		OTHER:	ome 5 🗆 Realdence	6 🗆 Other	(Specify)				
	Pending Investigation	28a. DATE OF IP (Month, Day,	NJURY (Year)	28b. TIME (RY V	NJURY AT VORK? YES 2 NO	28d. DE\$	CRIBE HOW	INJURY OCC	CURED		Ng.
3 Suicide 8 🔲	Could not be determined	28e. PLACE OF building, et	INJURY — At he tc. (Specify)	ome, farm, stre	eet, factory, of	lica	28f. LOCA City o	TION (Street or Town, State	end Number 9)	or Rural Ro	ute Number,	
conduction only		IAN: To the best of m									and mannar as at	ated.
29b. SIGNATURE AND TITLE	OF CERTIFIER					29c. LICENSE NU	JMBER		29d. DATE	E SIGNED (Month, Day, Year)	
Tawarit	9697	cen)				10446	+30	<u> </u>	10	6 -	04-2	004
30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUSE	OF DEATH (ITE	M 27) (Type, P	rint)							1
5309 6	1 02) Con	ZI R	D 1	(INA)	ALLSTO	Now	MS	2/	133	3	
31. DATE FILED (Month, Day,	Year)	32. REGISTRAR	'S SIGNATURE	4	1 .							
A LALH	Anne a	Bener	m K		parks							1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Day **Physician** 3,47 PM Edward JUNE /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death

Balfinore 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign **Funeral** Months Days Min 104M 20 F 112-42-1886 61 Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Example, must be invitited at 1 XYes 2 ☐ No Maryland

10e. Street and Number Funeral Director more 10g. Citizen of What Country? 10f. Zip Code 20 Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 Is marked other than " Elementary/Şecondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print (Sister) 20b. Place of Disposition cametery, crematory 20a. Method of Disposition 20c. Location - City or T wn, State 1 X Burial 2 ☐ Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Ad 21. Signature of Funeral Service Dicensee Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Crebro vasc Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' 1 ☐ Yes 2 No 2 0 NO To the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: Medical Certification; To 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 Could not be determined 3 🗀 Suicide within 24 hours after de To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers Baltimore St

Registrar DHMH 17 Rev 1/2001

State

2004 JUN 08

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2000

ORIGINAL

			For State Registrar	State of Man	/land / Depa		lealth and N	Mental Hygi	•	18057
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	John Franklin Haye 4a. Facility Name (If not institution, give s			4h City Town o	I continue of Dooth	May 3	1 2004	7.35 A ^M
	Examin	er	10 4th Ave S.W.	treet and number)		Glen Bu	Location of Death		4c. County of Death	
	Funeral		Social Security Number 6. Sex		n yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,		nplace (State or Foreign untry)
	Director		229-20-9356	M 2□F 78	Yrs.	Wioninis Days	Tiodis Will.	June 10,		ginia
	yland		10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	e Mar Sa-f st	Director	MD Anne Arun	del	Glen Bur	nie				1 ☐ Yes 2 X No
	with th		10e. Street and Number			10f. Zip Code		109	g. Citizen of What Cou	untry?
	ns 23	Funeral	10 4th Ave S.W.	12. Was Decedent Eve	r in U.S. 13. 1	21061 Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	U.S.A.	ican Indian,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Madical Exaciling must be natified at once.	by	1 Never Married 2 Married 3	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		f Yes, specify Cuba 1 □ Yes 21∏ No	n, Mexican, Puerto Specify:	Rican, etc.)	Specify: Wh	
2	72 ho 'natur	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup	during most of work	sing 16	6b. Kind of Business/I	ndustry
7	within ene. then	Jumo	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired nager	1)		Grocery	
<u>d</u>	illed Hygie other	Be Co	17. Father's Name (First, Middle, Last)		ria	mager	18. Mother's Nam	e (First, Middle, Ma		
<u>Jar</u>	Menta Menta arked artic ev	To B	John Franklin Haye	s			Helma C	. Griffir	ı	
Maryland 21215-0036	12 sho h and 7 Ismu raum		19a. Informant's Name/Relationship (Typ						City or Town, State, Zi	ip Code)
	1 and Healt Iem 2		Mr. Jeffrey Hayes 20a. Method of Disposition		///4 20b. Place of Dispo cemetery, cren	Old Hous sition (Name of	se Road		Md 21122 Oc. Location - City or T	own, State
ē	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ro `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Glen H		June 2	Δ.	len Burnie	
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service License	MO1:	220 1	Second A	ss of Facility Si	ngleton F	uneral Honie, MD 210	ne PA.
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the						Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Chron	ic Obat	methe	- Fulm	mar of	USUNR	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of);			7		
		Jer	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of					
	acuted ind transit	Examlner	that initiated events							
760,	ficate be executed physician and is the burial-transit	cal Ex	resulting in death) Last	Due to (or as a co	onsequence of);					
687	ficate physics the		d	,				POTEN -		
Вох	leath certificat attending phy I for use as the	In/M	230. Was decedent pregnant	3c. If yes, outcome of p		Ectopic pregnancy			23d. Date of deliv	rery
о. О	The law requires that the death certifica te has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tim		Other (specify)			M <i>o</i> nth	Day Year
<u>a</u>	res that the de igned by the a be detached f		Part II. Other significant conditions con	tributing to death but n	ot resulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Records,	w requires been sign should be	ed by						1 ☐ Yes	2 ☐ No 3 ☐ Pro	bably 4 Honknown
000	ne law re has bee ge 2 sho	Completed						24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
		Com						performe	death?	
Viita	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital:		Othe	200	h (Check only one)		
	ding Phys h. After this funeral dir	-	27. Manner death	28a. Date of Injury	2 ER/Outpatien 28b. Time of	28c. Injury	at	me 5 dendendendendendendendendendendendendend	ce 6 □Other (Speci injury occurred	fy)
ion	Attending r death. ector: After by the fune	atlo	1 Lural 5 Pending 2 Accident investigation	(Month, Day Ye	ear) Injury	M 1 🗆	Yes 2□No			
Division	afte Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	At home, farm, stre Specify)	eet, factory, office		28f. Location (Stree City or Town,	et and Number or Rur State)	al Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	ledical C	29a. Certifier (Check only one) 1	icien: To the best of m er: On the basis of ex and manner stated	amination and/or inv	n occurred at the time restigation, in my op	ne, date and place, pinion, death occur	and due to the caused at the time, date	se(s) and manner as s a and place, and due t	stated. o the cause(s)
	To the within To the Comple	Me	29b. Signature and title of dertifier			29c. License	number	29d	. Date signed (Month,	Day, Year)
	/		* Whates	0		D.	1192=	7	6/1/04	
	15	Ì	30. Name and address of person who col	mpleted cause of death	(Item 23a) (Type,	Print)	1 2	1 2 -	1	2 21/22
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Monte	UN CE	ige two	very Mil	MIN
	Registr		JUN 0 8 2004	Dengua	19 19	south				

State of Maryland / Department of Health and Mental Hygiene 2 🛭 🐧 👢 18058 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year *Physician JUNE Barbara Harter 05 5.238M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes Health Cane BALTIMORE N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1□M 2√2F 90 216-32-8029 Director JUL 6, 1913 Romania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ₹ No Director Catonsville Maryland Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? or iteme 23g or 21228 USA 1 Maple Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if tiem 27 is marked other than "neturel", or tier eny injury or other treumatic according to the contract than "neturel", or tier only injury or other treumatic according to the contract than "neturel", or tier only injury or other treumatic according to the contract than "neturel", or tier only injury or other treumatic according to the contract than "neturel", or tier only injury or other treumatic according to the contract than "neturel", or tier only injury or other treumatic according to the contract than "neturel", or tier only injury or other treumatic according to the contract than "neturel" or tier or the contract than "neturel" or the contract than "net Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: þ 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Seamstress Coat Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Anna Schag Michael Fck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 Maple Avenue Catonsville, MD 21228 Anna Steffen/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 6/9/04 Good Shepherd Cemetery Ellicott City, MD 21. Signate of Funeral Service Licensee

Edward A. regorchik 22 Name and Address of Facility Home, P.A. 301 Frederick Road Cátonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Due to (or as a consequence off. day /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed Due to (or as a consequence of): the attending physician P.O. Box 68760 Physician/Medical as the l 23c. if yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à Kenal 1 Yes 2 No 3 Probably Unknown Univary 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 22No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Unpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 28a. Date of Injury (Month, Day Year) After thi funeral (28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Guither Nally. MD P17599 June 05 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. ANITHA NALLU, St. Agnés Health Cost St. Agnes Health Case, 9005, Caton Ave, Baltimore 21229 H. 31. Date filed (Month, Day, Year) 32. Registrar's Signature MARCIA JUN 0 8 2004 Registrar

DHMH 17 Rev 1/2001

BARBARA

		,	1 - For Amend Item 8 p	Staten (1832/1889	08/104 Cen	itment of H	ealth and I Death			18059
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last) Wendy Hers 4a. Facility Name (Find institution, give s.)	Stein treet and number)		4b. City, Town, or	Location of Death	2. Date of Death Month	Day Yeer 5 2004 4c. County of Death	3. Time of Death
9 48	Funeral Director	eı	University of Man 5. Social Security Number 6. Sex	gland Hospital	st birthday)		If Under 24 Hrs. Hours Min.	MD	N/A 4/11/40 9. Birth 964	N.Y.
	a-f show	ctor	10a. State 10b. County MD ANNE ARUNI		Town or Loc	eation				10d. Inside City Limits 1 ☐ Yes 2 No
	illed within 72 hours after death with the Maryland Hygione. ther than *natural*, or items 23a or 28a-(show int, tra Me Jical Examinat must be notified at	Funeral Director	10e. Street and Number 334 HAMLET CIRCLE 11. Marital Status	Was Decedent Ever in U.S Armed Forces?	6. 13. W	10f. Zip Code 21037 /as Decedent of Hi Yes, specify Cubar	spanic Origin? (S	pecify Yes or No-	U.S.A. 14. Race - Americ Black, White,	can Indian,
-0036	hours after itural', or it	Ď	1 Never Married	1 Yes 2 No If Yes, Give X Year or Dates:	1	Yes 2 No	Specify:			ITE
9500-91212	ed within 72 ygiene. ier than "na t, the Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give k	aind of work done d O NOT use retired;	uring most of wor	king	NINDOW COVE	
⊆ .	should be fit ind Mental Hy is marked oth umatic even	To Be	17. Father's Name (First, Middle, Last) WILLIAM VICTOR 19a. Informant's Name/Relationship (Type	SCHNEIDER	19b. Mailing	Address (Street a	ADELE	ne (First, Middle, M	laiden Sumame) ROTT City or Town, State, Zip	
	1 and 2 Health a em 27 is ther tra		STEPHAN HERSTEIN/HU 20a. Method of Disposition	JSBAND 20b. Pl	334 HA	AMLET CIR lition (Name of atom or other place	CLE EDG	SEWATER, N	MD 21037 Oc. Location - City or To	own, Stete
Baltimore,	permit. Pages Department of I Important: If its any injury or o		1 Burial 2 Cremation 3 MRe '4 Donation 5 Other (Specify) 21. Signatur of Inneral Service Licenses	10	22.	Name and Addres	s of Facility SO	L LEVINSO	ARMINGDALE, ON & BROS.,	INC.
英	hysician /Medical		23a. Part 1. Enter the disease, or complit shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e caese on each line. Non-Small	Do not ente	r the mode of dying	g, such as cardiad		IKESVILLE,	Approximate Interval Between Onset and Death
	sician and sician and purial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a consequence to (o	ence of):					
. Box 68/	death certificate e attending phy: ed for use as the	Physician/Medical							23d. Date of delive	ery Day Year
7	faw requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions con	tributing to death but not resu	lting in the un	derlying cause give	n in Part I.		acco use contribute to the	
ř	The ate h page	Completed						24a. Was an autopsy perform	prior to co	psy findings available mpletion of cause of
or Vita	ding Physician: Th n. After this certificate funeral director, pag	n: To Be	27. Manner of Death		R/Outpatient 28b. Time of Injury	3□ DOA Othe	r: 4 🗆 Nursing H	oth (Check only one one 5 Resider 28d. Describe how	nce 6 Other (Specif	y)
~	or Attendition (fer death inector:	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	ne, farm, stre	M 1□Y	es 2∏No	28f. Location (Stre City or Town,	eet and Number or Rura State)	ıl Route Number,
	Hospit 4 hour Funer ely filt	Medical Co	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my know er: On the basis of examinati and manner stated.	vledge, death on and/or inve	occurred at the timestigation, in my op	e, date and place inion, death occu	, and due to the cau rred at the time, dat	use(s) and manner as s le and place, and due to	tated. the cause(s)
	To the within 2 To the complet	Σ.	29b. Signature and title of certifier		20-1/2		number	29	d. Date signed (Month,	Day, Year)
	2 L Sta	te	30. Name and address of person who con DCDYU HULLE 31. Date filed (Month, Day, Year)	- 100	Coreer	ne St, p	Baltimor	e, MD.	<i>81201</i>	
	Registr	ar .	UIN 0 8 2004	Deport L	7 A	200 /2/				

Physici /Media Examir

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Itema 23a or 28a-1 show any injury or other traumatic event, The Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit

Division of Vital Records, P.O. Box 68760,

Sta Registrar

	1 - For State Registrar	State of Ma		partment of H ertificate of I			ene No. 2 () ()	l laner		
	Decedent's Name (First, Middle, Las	st)				2. Date of Death		3. Time of Death		
an	ANNA M.	JONES				Month	Day Yea	1030AM		
er	4a. Fecility Name (If not institution, give		eet		Location of Death		4c. County of De	eath / A		
	5. Social Security Number 6. Se 220 05 77 11	ex 7. Age □M 2 ⊠ F	(In yrs. last birthday	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	(ear) 9.8	irthplace (State or Foreign Country)		
7.	Usual Residence of Decedent 10a. State 10b. County	4	10c. City, Town or t	Location				10d. Inside City Limits 1 ☑ Yes 2 □ No		
Il Directo	10e. Street and Number	eton st	<u> </u>	10f. Zip Code	21217	100	g. Citizen of What			
Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		B. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Black, Wi	nerican Indian, nite, etc.		
mpleted	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4or 5-	(Giv	edent's Usual Occupive kind of work done of DO NOT use retired	during most of work	king	b. Kind of Busines	s/Industry GDVCRNMEN		
Be	12th grade 17. Father's Warne (First, Middle, Last) FREDERICK D	2 years . WALKE	0	19 Junit		e (First, Middle, Ma	iden Sumame) L	NK		
To	19a. Informant's Name/Relationship (7 BALBALA DWG	Гуре, Print)	19b. Mai	iling Address (Street a			City or Town, State	12 -10 -1		
10.3	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	20b. Place of Disp cemetery, cri		(e)		C. Location - City of WINGS M			
	21. Signature of Funeral Service Licen				1			21229 IMORE MD		
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line	the death. Do not en					Approximate Interval Between Onset and Death		
Ilcal Examiner	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c									
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23d. Date of d Month								
ed by Pt	Part II. Other significant conditions or	ontributing to death bu	t not resulting in the	underlying cause give	en in Part I.			to the cause of death? Probably 4 □Unknown		
Complet						24a. Was an autopsy performe	24b. Were a prior to death?	autopsy findings available completion of cause of s		
Be	25. Was case referred to medical examiner?	Hospital:		0,5		h (Check only one)				
To	1 Yes 2 No	1 ☐ Inpatien			4 🗆 Nursing no			ecify)		
tlon	1 ☑Natural 5 ☐ Pending	(Month, Day	Year) Zob. Tille	Work	Yes 2 No	28d. Describe how	muly occurred			
Medical Certification:	2 Accident 3 Suicide 4 Homicide		ry - At home, farm, s (Specify)		103 2 INO	28f. Location (Stree City or Town, S	et and Number or F State)	Rural Route Number,		
dicalC	29a. Certifier 1 Certifying Phy (Check only 2 Medicel Exem	ysicien: To the best of niner: On the basis of and manner stat	examination and/or i	ath occurred at the timinvestigation, in my op	ne, date and place, pinion, death occur	and due to the caus red at the time, date	se(s) and manner a a and place, and du	as stated. ue to the cause(s)		
Me	29b. Signature and title of certifier	a C 9.	Hayle	29c. License	742Y	29d	Date signed (Mor	onth, Day, Year)		
	30. Name and address of person who delicated - Gra	escle 11	6 S. Ent.	C+ C1	2 400 B	altimor	e mo	2120/		
te ar	31. Date filed (Month, Day, Year)	32. Registra	'a Signature	" Specie	7		/	,		

			_ FOI	State of Maryland			Mental Hygi	ene 2006	18061
			State Registrar 1. Decedent's Name (First, Middle, Last)		Certifica	te of Death	Re 2. Date of Death	g. No.	3. Time of Death
	Physicia	_	Bervice J	. Johnso	, w		Month MAY	Day DOOL	1 2249M
1	/Medic Examin		4a. Facility Name (If not institution, give str	, ,	4b. City	y, Town, or Location of Deat	1	4c. County of Death	.,
			5. Social Security Number 6. Sex	€ 1 6 € N . 19 7. Age (In yrs. las	st hirthday) If Und	funagor	8. Date of Birth	9. Birth	nplace (State or Foreign
	Funeral Director			1 212F 57	Yrs. Months	Days Hours Min.		1948 Mu	yland
T	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, **	Town or Location			11 8 1	10d. Inside City Limits
	or 28a-f show	tor	Maniford Anne Ar	undel A	nnapolis				1 2 Yes 2 No
:	or 288	Director	10e. Street and Number	1		ip Code	10	g. Citizen of What Con	untry?
	eath w	Funeral	908 E, Copeland S	. Was Decedent Ever in U.S.	13. Was Dec	edent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Amer	
5	atter dea or items		1 Never Married 2 Married	Armed Forces? 1 □ Yes 2 1 1 No	If Yes, sp	ecify Cuban, Mexican, Puerl	o Rican, etc.)	Black, White	
3	filed within 72 hours after death with the Maryland Hygiene, then "natural", or Items 23a or 28a-1 show ant, the Modical Examination must be multified a	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	16a. Decedent's Us	in literature		Specify: E	Slack
2	n "nat	piete	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)		(Give kind of w	rork done during most of wor use retired)	rking	bb. Kind of Business/i	/
7	ed with ygiene er tha t, the	Completed		College (1-401 34)	Treasur		ist	Governn	nent
	2 should be filed with and Mental Hygiene, is marked other that aumatic event, the	Be	17. Father's Name (First, Middle, Last)	1.+-		18. Mother's Nar	ne (First, Middle, M	11	A 1
, i	should be nd Mental marked c umatic eve	္	19a. Informant's Name/Relationship (Type	a, Print)	19b. Mailing Addre	ss (Street and Number or Ru	ral Route Number,	JONN 50 City or Town, State, Z	
À	and 2 ealth a n 27 is		Dana Kelly		120 War	wickshire L		n Burnie, 1	1D 21060
5	Pages 1 nent of H int: if ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	-007	ce of Disposition (N	other place)	Date 2	Oc. Location - City or 1	own, State
	- 5 2 5		*4 □ Donation 5 □ Other (Specify)	1	22. Name	and Address of Facility	7	/Thnapolis	MD
ă	permi Depar Impor any ir once.		Gerffrey K.W.		Miller	5 Metropolitan G	hupe/1922:	Forest Dr. A	nogolismo
			23a. Part1. Enter the disease or complic shock, or heart failure. List only one	ations that ceused the death.	Do not enter the mo	ode of dying, such as cardia	c on respiratory arres	st,	Approximate Interval Between Onset and Death
F	Physician /Medical		Immediate Qayse (Final disease or condition resulting in death)	Due to (or as a conseque	UIPA	+10 N			
i	Examiner		Sequentially list conditions. b.	GASTROSI	<u>·</u>	val He	morrh	Age	
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	nce of):				
Ś	execu an and rial-tra		that initiated events c. resulting in death) Last	Due to (or as a consequen	nce of):				
0 10	cate be executed bhysician and the burial-transit	Physician/Medical	d.						
) {	death certifica a attending ph d for use as tt	/Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregnance				23d. Date of deli-	very
Ď :	s death he atte ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal de 4 Pregnant at time of dear 9 Unknown				Month	Day Year
ָ	sician: The law requires that the de certificate has been signed by the ; rector, page 2 should be detached		9 Unknown Part II. Other significent conditions cont		ing in the underlying	cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ה מ	quires in signi uld be	ed by					1 ☐ Yes	s 2 No 3 Pro	bably 4 Anknown
2	law recast been as been 2 short	Completed					24a. Was an autopsy	prior to c	topsy findings available ompletion of cause of
ב ה	i: The icate h r, page							ZNo 1 ☐ Yes	2□ No
7	/siciar s certif directo	To Be	25. Was case referred to medical examiner? 172 Yes 2 \(\text{No} \) No	spital: 1 ☐ Inpatient 2 🔀 EF	R/Outpatient 3 ☐ [Othor	ath <i>(Check only one</i> dome 5 - Resider	nce 6 ⊡Other (Spec	ifv)
5	ding Phys		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer)	8b. Time of Injury	28c. Injury at Work?	28d. Describe how	w injury occurred	
20	uttendi death. ctor: A y the fu	licati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hom	M ne. farm. street. facto	1 Yes 2 No	28f. Location (Stre	eet and Number or Ru	ral Route Number,
2	s after s after af Dire ed in b	building, etc. (Specify) City or Town, State)							
Į.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, Atten this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of my knowled: On the basis of examination and manner stated.	ledge, death occurre on and/or investigation	nd at the time, date and place on, in my opinion, death occu	e, and due to the car urred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 3	Med	29b. Signature and title of certifier	Den		9c. License number		d. Date signed (Month	. Day, Year)
	1		Million or	atomo	1	D0605	7	5/21/	14
	4		30 Name and address of person who cor	1-	23a) (Type, Print) n D	D0605	revir.	A 210	735
	Sta		31. Date filed (Month, Day, Year)	32. Regisear's Signatur	re H 1	M.	-1001		
	Registi	rar	MAY Z 3	LUUT PARTIE	Ar And	467.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 11:45AM errsa bucs 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimerc SECOURS fos NIA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sax Birthplace (State or Foreign Country) **Funeral** Months 216-76-8726 1 □ M 2 🖳 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show other treumatic event, the Mudical Examinar must be notified at 1 Yes 2 No Director MARILAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 Items 23a U5A Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: BLACK 3 Widowed 4 Divorced "neturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 THGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental H TAMES MCMILLAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 BROCKEBURY DR. APT item 27 I ELETCH GROSS (DAUGHTER REISTERSTOWN MD. 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō Department of Importent: If it any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CREMATORY 06-04-04 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of acility BROWN JOSERHHH. BROWN 2140 N. FULTON AVE 21. Signature of Funeral Service License BROWN JR. FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Onknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 410 of Vital To the Hospitel or Attending Physicien: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural death. 1 🗌 Yes 2 🗌 No 2 Accident after death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

29b. Signature and title of certifier

MON

31. Date filed (Month, Day, Year)

JUN 0.8 2004

30. Name and address of person who completed cause

DHMH 17 Rev 1/2001

of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date signed (Month, Dey, Year)

			1 - For State Registrar			epartment of Certificate of		Mental Hygie	2001	18063
	Physici /Medi		1. Decedent's Name (First, Midd HAROLD Z	(e, Last) A Y				2. Date of Death	Day Year 7, 2001	3. Time of Death 3. 25 PM
7	Examir		4a. Facility Name (If not institutio		A CONTRACTOR OF THE PARTY	4b. City, Town,	or Location of De	ath	4c. County of De	ath
	F		BALTIMOPE REHABL. 5. Social Security Number	6. Sex 7. Ac	DED CA	av) If Under 1 Yea	If Under 24 H	S. 8. Date of Birth	NA a R	inthe lean (State as Familia
н	Funeral Director		272-30-3861	1 ⊠ M 2□F	67	Months Day				irthplace (State or Foreign Country) Ohio
	pu ,		Usual Residence of Decedent					2-3-37		
	show	70	10a. State 10b. County		10c. City, Town o					10d. Inside City Limits 1 Yes 2 □ No
	28a-f	Director	Md. 10e. Street and Number	NA		Baltimore	ļ. —	10-	035 - 4345 - 4	
	th with 23a or	D	5143 Stafford	Rđ.		10f. Zip Code	229	log.	Citizen of What C	country?
	death	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	3. Was Decedent of If Yes, specify Cu		Specify Yes or No-	14. Race - Arr	
98	after des or Itams	/Fu	1 Never Married 2 Mar	ned 1 □Yes 2 total	No	1 ☐ Yes 2 ☑ No		erto Rican, etc.)	Black, Wh	
21215-0036	hours after death with the Maryland tural; or Itams 23a or 28a-f show al Examinat must be notified ut	d by	3 ☐ Widowed 4 ☐ Divorced		10.0	•••				Black
15	in 72	piete	(Specify only highe	it's Education st grade completed)	(G	cedent's Usual Occi ive kind of work don e. DO NOT use retir	e during most of w	orking 16t	. Kind of Busines	s/Industry
212	d with giene. rr thau	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4or !	5+)	Counselor	,			
	al Hyg	Bec	17. Father's Name (First, Middle,	Last)			18. Mother's Na	ame (First, Middle, Mai	den Surname)	
yla	E should be filed within 72 hours and Mental Hygiene. Is marked other than "natural", sumatic event, I're Medical Era	To	Harold		Jay		Viola		Mot	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hygiene. It was a state of the than "natural", or Itams 23a or 28a-1 show itam 27 is marked other than "natural", or Itams 23a or 28a-1 show other traumatic event. Its Medical Exanting must be rediffed at	1 7	19a. Informant's Name/Relations Madeline Jay					Rural Route Number, Ci Baltimore, I		
	1 and Healt Ism 2	i	20a. Method of Disposition	Daughter	20b. Place of Di	sposition (Name of			Md. 212:	
JOE	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		cemetery, t	crematory or other pl	, I		1797	
Baltimore,	- 두 만 근		21. Signature of Funeral Service		Galli	Son Forest 22. Name and Add				ills, Md.
0	Depa Impo	0 1	Pol of	up W an	ner	March F.	H. East	1101 E	more, Md. North A	. 21202 Ave.
>	Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. LUNG	ne.			ac or respiratory arrest,		Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed in the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, badding to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last							
O. Box	that the death certifice hed by the attending pr detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pregnand 5 □ Other (specify)	су		23d. Date of de Month	elivery Day Year
rds, P.	w requires that been signed b should be deta	þ	Part II. Other significant condition	ons contributing to death by PR65TA	ut not resulting in the	underlying cause gi	iven in Part I.			o the cause of death?
of Vital Records,		Completed						24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
Vit	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ot	4	ath (Check only one)		
of	g Physie ter this neral di	5. To	1 ☐ Yes 2∰ No 27. Manner of Death	1 Linpatre	nt 2 ER/Outpat	ient 3 DOA	4 Nursing	Home 5 Residence		ocify)
ion	nding ith. :: Afte e fune	atior	1 Natural 5 ☐ Pendin 2 ☐ Accident investig		Year) Injur	y Wo	ork?]Yes 2 □No	Edd. Bosoned Now III	jury occurred	
Division	To the Hospital or Attending Physicien: within 24 hours after deals. To the Funaral Director: After this certific completely filled in by the funeral director,	27. Manner of Death 1 Manual 2						28f. Location (Street City or Town, St	and Number or Ri ate)	ural Route Number,
	To tha Hospital within 24 hours To ths Funaral completely filled	edical	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the best of Examiner: On the basis of and manner sta	examination and/or	ath occurred at the tinvestigation, in my	ime, date and plac opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as nd place, and due	s stated. e to the cause(s)
	ro the	Me	29b. Signature and title of certifie		nou.	29c. Licen	se number	29d. [ate signed (Mont	h, Day, Year)
	. , , ,	1	* Herry (i lan, t	u.D.	D	1495	8 UNY	27 2	104
	1/1	1	30. Name and address of person		eath (Item 23a) (Typ	e, Print)	<u>, , , , , , , , , , , , , , , , , , , </u>	IFYT I	J-1/ 9	1
	- 1		AURORA C. TAN	3900 LOCK	RAVEN	BOYLEVA	RD BALT	IMORE, M	D 2/2	18
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	sporks	, (

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 4 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth Day 2004 Month MAY 4-00AM JANES JONES 28 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death MULTI MEDICAL Truson If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 54 Yrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign MAKY/LAND) Days 214 · 50 · 2172 Usuel Residence of Decedent 100 M 2□ F 10c. City, Town or Location BATIMURE 10a. State 10b. County 10d. Inside Pity Limits MD 1 Nes 2 No 10g. Citizen of What Country? U.S.A. 10e. Street end Number WINSTON 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married BLACK 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TRANSPORTATION DKIVER 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) MARI 19b. Mailing Address (Street and Number or Rural Floute Number, City or Town, State, Zip Code) WINSTON ALE. Date UNK 20c. Location - City or Town, State 20b. Place of Disposition (Name of UNK 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State BACT MORE MANU LAND 22. Name and Address of Facility VAVAHN C. GREENE TUNKER HOME 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee BATIMORE, MARYLAND 21212 4905 YORK ROAD 23a. Part1. Enter the disease, occumplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on eech line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) END STAGE MONTHS Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 12 Yes 22No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2□No Other: 4 Universing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

Director

Funeral

δ

Completed

Be

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumstic event, the Medical Examiner must be notified at

pemit. Peges 1 and 2 should be filed within 72 hours efter i Depertment of Haalth and Mental Hygiene. Important: If item 27 is merked other than "natural", or ther any injury or other traumetic event. The Medical Exemi-

altimore, Maryland 21215-0020

attending physician end I for use es the buriel-transit Division of Vital Records, P.O. Box 68760,

Physician/Medical |

þ

Be Completed

Certification: To

Medical

27. Menner of Deeth

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

1 Naturel

Hospital or Attending Physician: The law requiras that the death certificate be executed s efter death.

24 hours completely within 2

31. Dete filed (Month, Day, Year) State

Registrar

29b. Signature and title of certifier Juphe MD 30. Name end address of person who completed ceuse of death (Item 23e) (Type, Print)

JUN 0 8 2004

5 Pending investigation

6 Could not be determined

QUPTA MD SHAKUNM ALA 32 Registrer's Signature

28a. Date of Injury (Month, Dey Year)

00053150

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

7700 ROAD, TOWSON MD YORK

28d. Describe how injury occurred

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			1 - For State Registrar	State of M	arylan	•	artment of H	Health and	, ,	giene Reg. No 2 () (18065
		3	Decedent's Name (First, Middle, Landson L	ist)					2. Date of Dea	ath	J 9	3. Time of Death
	Physici /Medio		Dorothy	V. Ke	elly				JUNE 3	Day 06,20	Year	2: 20p. M
	Examir		4a. Facility Name (If not institution, gi				4b. City, Town, o	or Location of Deat	h	4c. County	of Death	
			North Arundel He					n Burnie		Anne	Arı	ınde1
	Funeral			Sex 7.Ag 1□M 2X口F		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day	, Year)		place (State or Foreign intry)
	Director		216-14-3586 Usual Residence of Decedent		8.	1 113.			_April 5	5 1923	Mar	ryland
	yland Now		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	a-fsl	ctor	Maryland Anne A	rundel			Pa	sadena			1	1 ☐ Yes 2 X No
	ith th	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of W	/hat Cou	intry?
	ath w		316 Beach Avenue				21122					
	er de	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	_	.S. 13. \	Was Decedent of F f Yes, specify Cub	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race Black	- Ameri k, White,	ican Indian, , etc.
36	I', or	by F	1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:	No		1 □ Yes 2X□ No	Specify:		Specify:		White
ð	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show than "hedical Exain art must be rivilified at		15. Decedent's E	ducation		16a. Deced	ient's Usual Occup	pation		16b. Kind of Bu		
21	thin 7 e. en "n	ple	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5	5+)	(Give	kind of work done DO NOT use retire	during most of word)	rking			,
21	ed wi	Completed	10				Sales Cle			Departm		Store
ng L	be fill Ital H Id oth	Be	17. Father's Name (First, Middle, Las						ne (First, Middle,		e)	
ž	d Mer narka natic	^C	Robert E.	Hoop	er	401-14-15		Evely		ong		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Interportent: If item 27 is marked other than "natural; or Items 23a or 28a-f show eny injury or other traumatic avant, the Medical Examination at most be rediffied at once.		19a. Informant's Name/Relationship Linda Workley	(daughter)				and Number or Ru enue, Pas			State, Zij	o Code)
ā,	Heal Heal tam 2		20a. Method of Disposition	(dadgireer)	20b. P	lace of Dispo	sition (Name of			20c. Location - (City or T	own, State
Baltimore,	Pages ent of nt: If i		1 XBurial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Speci				natory or other place Cemetery				-	Maryland
äţį	mit. f partm portal / inju		21. Signature of Funeral Service Lice		1		. Name and Addre			s Funera	al H	ome, P.A.
m	Deparenti Deparenti Impo		Muschell	Stalk		1)	3111 Mour	ntain Roa	d, Pasad	ena, MD	211	22
н			23a. Part1. Enter the disease, or conshock, or heart failure. List only	one cause on each li	the deal	Do not ente	er the mode of dying	ng, such as cardiad	or respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	LONGE			HEART	FAIL	URE			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of):						
п		_	Sequentially list conditions,	b	2 0000000	uonco of):						
	nsit	Examiner	if any, leading to immediate Cause (Disease or injury	Due to (or as	a consequ	derice or,					1	
Ĭ.	execu n and ial-tra	Exal	that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):						
8760,	cate be executed physician and the burial-transit	dical		d								
9	rtifica ng ph as th	Aedi	IE ECHALC.									
Вох	eath certifi attending for use as	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy	,		23d. Date		
O.	ne death the atte hed for	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown			Other (specify)			Mon	th	Day Year
۵.	that the de ed by the detached	Phy	Part II. Other significant conditions	contributing to death b	ut not resi	ulting in the un	idarhying causa giv	en in Part I	23e Did tol	Pacco use contrib	buto to ti	he cause of death?
ds,	es De de	Completed by Physician/Me			3111011001	31111g 117 1770 GI	donying cadso giv	on an and a				pably 4 2 Unknown
Record	w requii been s should	lete							24a. Was a			
Re	he lay e has age 2	duc							autops	ned? pr	ior to co	psy findings available mpletion of cause of
Vital	10 17	O	25. Was case referred to medical					26 Place of Dea	1 ☐ Yes 2 th Check onl on		Yes	2 No
		To B	examiner? 1 □ Yes 2 2 No	Hospital:	nt 2 🗆 1	ER/Outpatieni	: 3□ DOA Oth		ome 5 Reside		- (Specifi	v)
n of	ding Ph th. : After th funeral	L:uc	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injui	y Year)	28b. Time of Injury	28c. Injur Worl		28d. Describe ho			,,
Sio	Attending ir death. actor: After by the fune	catle	2 Accident investigation	n		,,-		Yes 2□No				
Division	l or Attend after death Diractor: /	Certification;	3 Suicide 6 Could not be determined		ury - At ho c. (Specify	me, farm, stre	et, factory, office		28f. Location (St. City or Town	reet and Number n, State)	r or Rura	l Route Number,
	pital		29a. Certifier 1 Certifying Pl	unisia T. M. H. A.		1.1. 1.1.				V		
	To tha Hospital or At within 24 hours after of To tha Funeral Dirac completely filled in by	Medical	(Check only 2 Medical Example)	nysician: To the best on niner: On the basis of and manner sta	examinat	wieage, aeath tion and/or inv	occurred at the tin estigation, in my o	ne, date and place. pinion, death occui	and due to the ca red at the time, da	ause(s) and man ate and place, ar	ner as st nd due to	tated. the cause(s)
	To tha within 2 To tha complet	Me	29b. Signature and title of certifier				29c. Licens	e number	2	9d. Date signed	(Month,	Day, Year)
	C>F0		believe Ka	110 hun	v	MD	000	55473	7	UNE O	10:	200d
	M	13	30. Name and address of person who		eath (Item	23a) (Type, F		, , ,		J. 70		2004
	ノ		zeieke Des	e 11500	SU	Hnerle	and Hi	11 WOY	Silver	spring	~	0 20404
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registra	ar's Signat	ture &	Mark					

			1 _ State	State of Marylar	•	rtment of l		-	^	001		
		-	Registrar 1. Decedent's Name (First, Middle, Last)			ilicale of	Dealli	2. Date of De	Reg. No.	UUH	3. Time of Death (
	Physici		Grace Mary Koet	-he				MONE	Day	OTO 4	0040 M	
	/Medio Examir		4a. Facility Name (If not institution, give si			4b. City, Town,	or Location of De	ath	4c. Coun	ty of Death	000	
			UNIVERSITY SP	ECUALTY H	DSPITA	L E	altimore	<u> </u>		n/a	a	
	Funeral		5. Social Security Number 6. Sex	M 22 F 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		n. (Month, Da	th ly, Year)	Count		
	Director		216-94-4119 Usual Residence of Decedent	35	115.			Aug 26	, 1968	Mary	yland	
	yland yland		10a. State 10b. County	10c. Ci	ty, Town or Loc	ation				10	Od. Inside City Limits	
	a-fst	ctor	Maryland n/a		Baltin	ore					1 Yes 2 □ No	
	death with the Maryland rms 23a or 28a-f show rmust be notified at	Director	10e. Street and Number 1336 James Street			10f. Zip Code	223		10g. Citizen o		•	
	eath w	Funerai		2. Was Decedent Ever in U	IS 13 W	L		Specify Yes or No		ited S		
1	fter dear	Fun	1 ☑ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 21☑ No	If	Yes, specify Cut —	an, Mexican, Pue	irto Rican, etc.)	14. Race - American Indian, Black, White, etc.			
5-0036	s 1 and 2 should be filed within 72 hours after death wit f Health and Mental Hygiene. tiem 27 is marked other than "natural", or liems 23a oi other traumatic avent, the Medical Examinar must be	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 12 Year or Dates:	1	□Yes 25kNo	Specify:		Spec	Specify: White		
55	natural',	Completed	15. Decedent's Educ (Specify only highest grade		(Give k	nt's Usual Occu	during most of w	orking	16b. Kind of	Business/Ind	lustry	
2121	within one.	qm	Elementary/Secondary (0-12)	College (1-4or 5+)		O NOT use retire	nd)					
20	filed y Hygie other i	ပိ	17. Father's Name (First, Middle, Last)		⊥Manufa	cturer	18. Mother's N	ame (First, Middle,	T-Shir	t Fact	ory	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumetic avent, the Me	To Be	Elmer Roland Koeth	ne				Ellen S		nith		
a Y	shou and M a mar urnat	-	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing	Address (Stree	-	Rural Route Numb		n, State, Zip	Code)	
7,	is 1 and 2 of Health a item 27 is other train		Myrtle Koethe - Mo	other	1336	James S	treet, E	altimore	, Maryl	and 2	21223	
more	0 0	11 3	20a, Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Re		Place of Disposi cemetery, crema	tion (Name of atory or other pla	ice)	Date	20c. Location	- City or Tov	wn, State	
#\E	permit. Page Department o Important: If any injury or once.		4 ☐Donation 5 ☐ Other (Specify)	Ce	edar Hil	1 Cemet	ery 6/1	1/2004	Brookly	n Park	, Maryland	
Saff	permit. Departr Imports any inju		21. Signature of Funeral Service License	3. (1)	22.	Name and Addr	ess of Facility	Hubbard 1	Funeral	Home,	Inc.	
	44764		232 Part 1 Enter the disease of complete	ations that coursed the dead	41	07 Wilk	ens Aven	ue, Balt	imore,		nd 21229	
			23a. Part1. Enter the disease, or comple shock, or heart failure. List only one Immediate Cause (Final								Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	Acquire		www	6 0	efrien	1 71	nen	and	
	Examiner			Due to (6r as a consec	querice or):							
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):							
6	ecuted and I-transi	Examiner	that initiated events									
()		Ē	resulting in death) Last	Due to (or as a consec	quence of):							
8760	cate ohys the	dicai	d.									
9 X		/Me	IF FEMALE: 23	c. If yes, outcome of pregna	ancv				004 D			
Bo	eath certifi attending (for use as	Physician/Me	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	aldeath 3⊟E	ctopic pregnand Other <i>(specify)</i>	у			ate of deliver onth	y Day Year	
O.	it the d by the lached	nysi	1 ☐ Yes 2 🔼 No 9 ☐ Unknown	9□ Unknown								
Division of Vital Records, P.O. Box	Attending Physician: The law requires that the death certifir death. r death. actor: Atter this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	by P	Part II. Other significant conditions cont	ributing to death but not res	sulting in the und	lerlying cause gr	ven in Part I.	23e. Did to	obacco use cor	tribute to the	cause of death?	
rg	w require been sig should b							1 🗆 🕆	res 200 No	3 🗌 Proba	bly 4 ⊡Ünknown	
သို့	e law re has be je 2 sho	plet						24a. Was		Were autop	sy findings available pletion of cause of	
Ä	The tate has page	Completed						perfo	rmed? 2/20 No	doath?	No	
/ita	iician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					eath (Check only o	ne)			
of \	Physi this o	٤	1 ☐ Yes 2 ☐ No		ER/Outpatient	3 DOM	-	Home 5 ☐ Resid				
u	ding F h. After funer	ion	Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo M 1	ryat rk?]Yes 2 ∐No	28d. Describe I	now injury occu	rred		
isi	Attender deat ctor:	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome, farm, stree		103 2	28f. Location (5	Street and Num	ber or Rural	Route Number.	
Div	al or / s after l Dira d in b	Certification;	4 Homicide determined	building, etc. (Specil	(y)	,,		City or Tov	vn, State)			
	To the Hospital or within 24 hours affer To the Funeral Dir completely filled in		29a. Certifier 1 Certifying Physi (Check only 2 Medicel Exemine	cian: To the best of my kno	wledge, death	occurred at the ti	me, date and place	e, and due to the	cause(s) and m	anner as sta	ted.	
	he Ho in 24 he Fu pletel	Medical	one)	on the basis of examina and magner stated.	ition and/or inve	stigation, in my	opinion, death occ	curred at the time,	date and place,	and due to t	the cause(s)	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	Σ	29b. Signature and title of certifier	12-		29c. Licens	,		29d. Date signe		*	
			7			J	27 49		6- 1	Z-01	T	
	X		30. Name and address of person who con			·		_				
	Sta	to	Dr. Jayant Hirpara, 31. Date filed (Month, Day, Year)	601 S. Char. 32. Registrar's Signa	<u>les Stre</u>	eet, Bal	timore,	Maryland	21230			
	Registr			0 200	H	Acc. 4						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 503+ 200 KRMA IDWELL /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4pf. City, Town, or Location of Death Examiner A 0 Date of Birth Month, Day, Year If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 16 M 2/0 F **Funeral** Days Months Hours Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 2 No Director MORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 2408 Lane Items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married ŏ 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced naturel, Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "reny injury or other transmissions." College (1-4or 5+) is marked other then Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Sumame) Father's Name (First, Middle, Last) Be 10 ပ္ lowers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 6 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BALTI MORE MD 21234 Kenwer EVANS FUNERAL OHILFEL, 8800 HARFORD RE Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one by use on each live. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition **Physician** MARKEMIA /Medical resulting in death) Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ospira pour the attending physician The law requires that the death certificate be Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day detached for Month Year 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
1 ☐ Yes 24 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No Obes To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner?

1 X Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 DOA of this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Division 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 24 hours after death.
Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely within 2 To the 29d. Date signed (Month Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

OHMH 17 Rev 1/2001

ate filed (Month, Day,

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2004

22.

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Umms

		•	1 - State Registrar	te of Maryland /	Department of H Certificate of L	Jeath	Reg. No		
	Physici		1. Decedent's Name (First, Middle, Last) Betty	V. Kelley		2	Date of Death Month Date Manual Date Manua	o, 2004	3. Time of Death
	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, give street a low of the lo	7 - Bel AIN 7. Age (In yrs. last bi	Bel A	Hours Min.	Date of Birth (Month, Day, Year ept 11,	Coi	Inplece (State or Foreign unity) Maryland
	ט		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	wn or Location			1747	10d. Inside City Limits
	he Mary 8a-f sho	ector	Maryland HArfo	rd	10f. Zip Code	Edgewo		itizen of What Co	1 ☐ Yes 2/ŒXNo
	th with t 23a or 2 ist be n	ai Dir	3908 Walters Road		210	40		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic avent, the Modical Examinat must be notified at Once.	by Funeral Director	1 Never Married 2 Married 1 If Y	s Decedent Ever in U.S. ned Forces?]Yes XIXNo les, Give ar or Dates:	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes ※ ※ No	spanic Origin? (Speci n, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Amer Black, White Specify:	
2-00	n 72 hou natura	ieted	15. Decedent's Education (Specify only highest grade comp		a. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	luring most of working	16b. I	Kind of Business/	Industry
Maryland 21215-0036	od within giene. er then	Completed	6th	llege (1-4or 5+)	lomemaker			In own	home
and	d be file ental Hy ked oth c avent	To Be (17. Father's Name (First, Middle, Last) George Ambrose			18. Mother's Name (i	First, Middle, Maide y Gosnel		
lary	2 shoul and Mi Is mari	_	19a. Informant's Name/Relationship (Type, Pri		Bb. Mailing Address (Street a				(ip Code) 1and 21040
	ages 1 and nt of Health t: If item 27		George Beach 20a. Method of Disposition XXBurial 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	20b. Place	of Disposition (Name of ery, crematory or other place Lawn Memo Gardens	Dat	e 20c. l	ocation - City or	Town, Stete
Baltimore,	permit. P Departme Importent any injury		21. Signature of Funeral Service Loc See	enter	Gardens 22. Name and Addres Burgee-H 3631 Fa1	ss of Facility enss-Sei 1s Road	tz Funer Baltimo	al Hom	e. Inc. 21211
	Pnysician /Medical Examiner			s that caused the death. Do se on each line. Oue to (or as a cons y uence	o not enter the mode of dying				Approximate Interval Between Onset and Denth
8760,	cate be executed physicien and the burial-transit	dical Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events c.	Due to (or as a consequence					
.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as I	Physician/Med	in the past 12 months?	es, outcome of pregnancy Live birth 2 Fetal deat Pregnant at time of death Unknown	th 3 Ectopic pregnancy 5 Other (specify)			23d. Date of deli Month	ivery Day Year
<u>α</u>	quires that t n signed by uld be deta	þ	Part II. Other significant conditions contribution	ng to death but not resulting	in the underlying cause give	en in Part I.			the cause of death?
Vital Records,		Completed					24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
	ding Physicien: Th. After this certificate funeral director, pag	To Be	Natural 5 Pending	1 Inpatient 2 EFVC	. Time of 28c. Injury Work	4 at ursing Home	Check only one) 5		cify)
Division of	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	The state blue Could get be	. Place of Injury - At home, building, etc. (Specify)			f. Location (Street a City or Town, Stat		iral Route Number,
	e Hospita 24 hours e Funeral	Medical C	(Check only 2 Medical Examiner: O	To the best of my knowledgen the basis of examination and manner stated.	ge, death occurred at the tin and/or investigation, in my of	ne, date and place, an pinion, death occurred	d due to the cause(at the time, date ar	s) and manner as nd place, and due	stated. to the cause(s)
)	To th within To th comp	Me	29b. Signature and title of certifier		29c. License	4652	29d. D.	ate signed (Month	2004
	6		30. Name and address of person who complete	ad cause of death (Item 23a	Avenue Be	1 Ain 1	Mary Inn	1 21	014
	Sta Regist		31. Date filed (Month, Day, Year) JUN 0 8 2004	32. Registrar's Signature	Some	//			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month JUNE **Physician** 4:45p 2004 Gilbert F. Kunz /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Saint Joseph Medical Center Towson 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 7, 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1XXM 2□ F **Funeral** Months Days Hours Min Yrs. New Jersey 153-09-9648 91 1912 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10a. State 10c. City, Town or Location 28a-f show Items 23a or 28a-f shov ner rast by notified at 1 Yes 2 XNo Directo Maryland Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code #540 21204 1055 W. Joppa Road U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status other traumatic event, the Medical Examiner: filed within 72 hours after 1 Never Married Married 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐X Xo Specify: Specify þ 3 Widowed 4 Divorced White natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 12 Executive Department Store other t permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, 20x8. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frederick Anna Rapp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #540 Towson, Maryland 21204 Audrey A. Kunz Wife 1055 W. Joppa Road 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) 6-5-2004 Hilltop Service Corp! Towson Maryland 21. Sign tute of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician 6 Days eaking Iliac Artery Aneurysm /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate the sequence of the Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 21 No 2 No 1 Yes 1 Yes or All ending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To jo 27. Manner of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Division 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director: 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funeral Dire Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the l 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number a D 30263 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

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JUN 0 8 2004

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Osler Drive Towson, Maryland 21204

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 8 2004

32 Registrar's Signature

Maryland 21215-0036 Baltimore,

> P.O. Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Many land 1 Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 0836 (AM NETTIE **KRAMER** June 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore Hospital Sirai 0 Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year 10/05/1919 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplece (State or Foreign Country) **Funeral** 1□M 2□F 220-05-7205 84 Director MD Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 10d, Inside City Limits 1 ☐ Yes 2 ☑ No Directo BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8217 SCOTTS LEVEL ROAD 21208 U.S.A. Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1□Yes Z No WHITE 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "na any injury or other traumatic event, the Medic 2008. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 SALES WOMEN RETAIL DEPT. STORE 17. Father's Name (First, Middle, Last) Be (18. Mother's Name (First, Middle, Maiden Sumame) **JOSEPH** SIMON **CLARA GOLDBERG** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1305½ CABRILLO ÂVR. JUDY KRAMER/DAUGTHER VENICE, CA. 90291 06/06/2004 20b. Place of Disposition (Name of 20a. Method of Disposition BETH SAACatoADATH place) 1 X Burial 2 Cremation 3 Removal from State DUNDALK, MD 4 ☐ Donation 5 ☐ Other (Specify) I SPAEL
22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses Edward 1. Kusne 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** valve /Medical Due to (or as a consequence of): **Examiner** Respiratory Sequentially list conditions, it are leading to initial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Pe 2 X No Altered mental 1 🗌 Yes certificate has been sirrector, page 2 should ! 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 27. Manner of De th 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred al or Atternate at a state of the state of t After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier-29c. License number 29d. Date signed (Month, Dey, Year) equeura M.1. 00024726 Wune /6/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alejandro
31 Date filed (Month, Day, Year) 2411 W. Belvedere Ave., Suite Soz, Balt., MD, 21215 Dequeira 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

JUN 0 8 2004

			Please I	State of Maryland / Department		•	9	ble.		
			1 - State Registrar	· ·	rtificate of Death		0.0	04 1807	2	
	Physici	an	1. Decedent's Name (First, Middle, Last)		VEDDEI	2. Date of Dea	D .	3. Time of Death 2004 12:13 P M	-	
	/Medic Examin	cal	FLORE 4a. Fecility Name (If not institution, give s		KERBEL 4b. City, Town, or Location of Death	JUNE	4c. County		VI	
	Exami	iei	130 SLADE AVENUE		PIKESVII	LE	, and a starting	BALTIMORE		
	Funeral Director		5. Social Security Number 6. Sex 113-32-0418	7. Age (In yrs. last birthday). M 2 1 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	Y 9 10 33	Birthplace (State or Foreig Country) MD	วูก	
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	r 28a-f	Director	MD BALTI 10e. Street and Number	MORE PINE	SVILLE 10f. Zip Code		I0g. Citizen of V		_	
	ath with	rai D	130 SLADE AVENUE		21208			U.S.A.		
	ter des items	Funerai	11. Marital Status 1 XX Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (Spet Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Blac	e - American Indian, k, White, etc.		
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Baltimore,	Pages 1 ar		20a. Method of Disposition 1 🛱 Burial 2 □ Cremation 3 □ R	emoval from State	natory`cr other place)			City or Town, State		
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Ä	permit. Departiment import any nj		Acettril.		900 REISTERSTOWN					
Ĭ.			shock, or heart failure. List only on	cations that caused the death. Do not enti- ne cause on each the.	er the mode of dying, such as cardiac of	r respiratory arr	est,	Approximate Interval Between Onset and Death		
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rds,	The law requires that the ate has been signed by the page 2 should be detache	ed by	PARACO	PESU DIE TO CE		1 1 Y		3 ☐ Probably 4 ☐Unknown	1	
eco	law rea as bee 2 sho	Completed	Alrapic 1	RESPITATULY FAILURE	· ' '	24a. Was a		Vere autopsy findings available rior to completion of cause of	9	
a B	n: The icate h r, page					perform	ned? de	eath? □ Yes 2 □ No		
<u> </u>	ysiciar is certil directo	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{Y} \) No	ospital:	26. Place of Death 1 3 DOA Other: 4 Nursing Hor			er (Specify)		
n 0	ing Phi Mer thi Ineral		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury			w injury occurre		Ī	
Division of Vital Records,	ttendi death. ctor: A y the fu	ficati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, stre	M 1 Tes 2 No	28f. Location (St	reet and Numbe	er or Rural Route Number,	_	
<u>S</u>	lei or A s after at Direct	Certification:	4 Homicide	building, etc. (Specify)	ost, radisty, onto	City or Towr	n, State)			
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying Phys (Check only one)	sician: To the best of my knowledge, death ner: On the basis of examination and/or inv	occurred at the time, date and place, a restigation, in my opinion, death occurre	and due to the ca	ause(s) and man ate and place, a	nner as stated. nd due to the cause(s)		
	Mithin 2	Med	29b. Signature and title of certifier	and manner stated.	29c. License number	2	9d. Date signed	(Month, Day, Year)		
			> youh	MMY	y10034 (40	,)	June 2	,2004		
	10		30. Name and address of person who con	mpleted cause of death (Item 23a) (Type, I	Print) REE ROAD, SUITE 30	0 - RΔI	TIMORE	MD 21208		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	/	O DAL	, 11101\L,	IID LILOU		
	Registr	ar	JUN 0 8 2004	14 M	parky					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Robert Donald June 05 2004 0046 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford 8. Date of Birth (Month, Day, Year)
Dec. 31, 1927 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours XOKM 2□ F 238-34-9702 76 Director Kentucky Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examinar must be notified at Maryland Harford Bel Air 1 Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 1505 Donegal Road 21014 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No þ 3 Widowed 4 Divorced White natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Car Dealer Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil ment of Health and Mental H tant: If item 27 is marked oth James Guv Kilby Annie (u/k) Elledge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnne M. Kilby, Wife 1505 Donegal Road, Bel Air, Maryland or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. Bel Air Memorial Gardens 6/9/2004 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
ACCOMAS Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, de death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Maryland 21009 23a. Part . Enter the disease, or complications that caused the chock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiac **Physician** hour /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner use as the burial-transit signed by the attending physician and de detached for use as the burial-trar Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Cher (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Hunkhown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 Tes 2 No 2 Accident the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

ILBY, Kobert Donald or Attending Physician:

Maryland 21215-0036

Baltimore,

Director: tilled in by within 24 hours a

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 31. Date filed (Month, Day, Year)

29a. Certifier

U MD 5 32. Registrar's Signature

29c. License number

ess of person who completed cause of death (Item 23a) (Type, Print)

D 36715 06-07-04 520 Upper Chesapeake Dr. Stet 211 Bel Air MD sture

State Registrar



ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 004 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Vest KING ANDRE JUNE 13:33 M 2004 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 18/1/more Johns 5 S Date of Birth (Month, Day, Year) NOV 18, 1949 5. Social Security Number (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country)
 MD **Funeral** Days 18 M 2□ F 215-52-1907 54_{Yrs} Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exercities in 10d. Inside City Limits Director MD N/A Baltimore 1 No 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1233 N. Broadway 21213 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates: 1 ☐ Yes 2 No 3 ☐ Widowed 4 € Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) Self Employed Elementary/Secondary (0-12) College (1-4or 5+) Laborer 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Andre Maurice King Gloria Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn King/Daughter 7629 Wood Park Ln Apt. 101, Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Jun 5 Chesapeake Crematory Beltsville, MD 2004 21 Signature of Funeral Servi-Isee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Retroviral Acute Eight Years /Medical resulting in death) Due to (or as a consequence of) **Examiner** Distress Syndrome Respirator Acute SIX Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit Pneumonia Carinii Pneumo cystis Three weeks and that initiated events resulting in death) Last Due to (or as a conséquence of): the attending physicien Division of Vital Records, P.O. Box 68760 Pneumo thorax Physician/Medical Three days IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2 **2.** No 1□ Yes 2∏ No 1 Tyes the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification; To 1 Mnpatient 2 ER/Outpatient After this 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide In by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD RES-000 lune 2,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOCTOR ANAND PAREEN, THE JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BALTIMORE, MARYLAND, 21267 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 8 2004 Registrar

			For State Registrar	State of Ma	aryland	•	rtment tificate			ınd M		Reg	ene . No. 2 ()	104	18075
	Physici	an	1. Decedent's Name (First, Middle, Last)							2. Date of I		Day	Yeer	3. Time of Death
	/Medio		Jung Ok Lee 4a. Facility Name (If not institution, give	street and number)			4b. City. T	Town, or	Location of	f Death	June	3,	2004 4c. County	of Death	3:00 a ^M
1	Examili	iei	24 Odoen Court	,			•	rnev					_	timor	е
	Funeral		Social Security Number 6. Se		e (In yrs. Ia		If Under 1		If Under 2 Hours	24 Hrs. Min,	8. Date of E (Month,	Dav. Y	eer)		lace (State or Foreign try)
	Director		214-74-7970	□M 2 F	65	Yrs.					Nov.	6,	1938	Ko	réa
	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation							1	0d. Inside City Limits
	Many Fresh	ģ	MD Baltimor	e		Carn	ev								1 ☐ Yes 2 ☒ No
	be filed within 72 hours after death with the Maryland stat Hygiene. od other then "natural", or Iteme 23a or 28a-f ahow event, I're Medical Exeminar must be notified at	Director	10e. Street and Number				10f. Zip (Code				10g	. Citizen of	What Coun	try?
	ath wi	ie	24 Odeon Court					212				-L	United		
	er des	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		. 13. V	Vas Decede f Yes, speci	ent of Hi	spanic Orig n, Mexican,	gin? (Spe , Puerto	ecify Yes or f Rican, etc.)	No-		ck, White,	
36	rs aft		1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 N If Yes, Give Year or Dates:	NO	1	∐Yes 2	No 🔯	Specify:				Specif	v: Ka	rean
9	2 hou	ted	15. Decedent's Edi	cation		16a. Deced	lent's Usual	Occupa	ition	- 6 4 - 1		16	b. Kind of B	usiness/Inc	dustry
215	- 34	Completed by	(Specify only highest grad	College (1-4or 5	i+)		kind of work DO NOT use		uring most)	OF WORK	ng				
2	filed wi Hygien ther th		В			Entr	eprene	eur					elf En		ed
Maryland 21215-0036	2 should be filed withir and Mental Hygiene. Is marked other then sumatic event, Ira M.	Be	17. Father's Name (First, Middle, Last)						Pil	100	e (First, Midd Vam	_{ие, ма} Ра		ne)	
Ž	d 2 should th and Men 7 Is marke traumatic	은	Sup Jun Kim 19a. Informant's Name/Relationship (T	voe. Print)		19b Mailin	a Address	(Street a			I Route Num			State 7in	Code)
	12 mg	n i	Michael Lee/son	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		24 Ode						212		Ciaro, Lip	0000)
Baltimore,	Head Head		20a. Method of Disposition		20b. Pla	ce of Disponentery, cren	sition (Name	e of	1		ate	,	c. Location -	City or To	wn, State
Ë	Page ent or: If		1 X Burial 2 ☐ Cremation 3 ☐ I 14 ☐ Donation 5 ☐ Other (Specify,	Removal from State		•		-	. 1	6/07	/2004		Sykes	wille	MD
alti	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Lorns				. Name and		-						ork Road
_	807 2 2	U)	XIVII V Cost											owson	,Md.21204
			23a: Part 1. Enter the disease, or comp shock, of heart failure. List only of	ne cause on each lin	the death.	Do not ente	er the mode	of dying	g, such as o	cardiac o	r respiratory	arrest	,		Approximate Interval Between Onset and Death
	Pnysician /Medical	9 9	Immediate Cause (Final disease or condition resulting in death)	a Liver		rrhos	515								
	Examiner			Due to (or as	a conseque	ince of):									
		ĕ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause Observed or highly	b Due to (or as	a conseque	nce of):									
	d d ansit	Examine	cause. Enter Underlying Cause (Disease or highly that initiated events	c											
o,	e exec an an irial-tr	Exa	resulting in death) Last	Due to (or as	a conseque	nce of):									
8760,	cate be executed physician and the burial-transit	dicai		đ											
9	death certificate be executed e attending physician and of for use as the burial-transit	/Mec	IF FEMALE:	23c. If yes, outcome	of pregnan	nv.							1		
Box	attend for us	Physician/Me	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal d	leath 3□	Ectopic pre Other (spe						1	te of delive Inth	ry Day Year
o.	at the de by the a tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	1,1110 01 000		101101 (300								
σ,	law requires that the as been signed by th 2 should be detache	by Pi	Part II. Other significant conditions co	ntributing to death b	ut not result	ing in the ur	nderlying ca	use give	n in Part I.		23e. Dio	tobac	co use cont	ribute to th	e cause of death?
Records,	w require been sig should b	ed b									1 [] Yes	2 No	3 Proba	abiy 4 □Unknown
ဝ	e law re has beo je 2 sho	piet									24a. Ws	is an	24b. \	Were autop	esy findings available appletion of cause of
Ä	The ate h page	Completed									per 1 ☐ Yes	forme	1? No	death?	
of Vital	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?					Lau		of Death	(Check only	one)			
of	Phys this al dir	은	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatie		R/Outpatien		-	4 Nur	_	ne 5 He)
	ling After fune	ᇋ	1 XNatural 5 ☐ Pending	28a. Date of Injui (Month, Day	Year)	Injury	M	c. Injury Work	ai ? ′es 2.⊟N		28d. Describe	a now	injury occurr	90	
Division	or Attending after death. Diractor: After in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ury - At hom	ie, farm, stre					28f. Location	(Stree	t and Numb	er or Rural	Route Number,
Ö	5 g g g	Certification;	4 Homicide	building, etc	c. (Specify)		•				City or T	own, S	State)		
	To the Hospital within 24 hours a To the Funeral t completely filled	edicai (29a. Certifier (Check only one) 2 ☐ Medical Exam	sician: To the best of iner: On the basis of and manner sta	examination	edge, death on and/or inv	occurred a restigation, i	t the tim in my op	e, date and inion, deat	place, a	and due to the	e caus e, date	e(s) and ma and place,	inner as sta and due to	ated. the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier	111	1		29c.	License	number			29d.	Date signed	d (Month, E	Day, Year)
			1 my	,,,,	14		D	00	392	97			6/	3/0	4
	3		30. Name and address of person who c	K. K	0	23	Print)	E		ZQ	PPA	1	ld !	Sut	let
	Sta Registr		31. Date filed (Month, Day, Year)	Separate Separate	ar's Sighatu	lo lo	uks				' '		,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Margaret Lomas JUNE 6. 2004 8:25a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Renaissance Gardens Catonsville Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months 219-12-0681 82 AUG 18. Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Example Transported. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1X Yes 2 □ No Completed by Funeral Director N/A Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 806 Kingston Road 21212 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Secretary Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Claude Garrettson Buckingham Adah Myrle Caple 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Faye Mackall/daughter 806 Kin ston Road Baltimore, MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 6/7/04 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service ²²Clame and Address of Facility of Maryland, Inc. Dawn F. McDornald

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 299 Frederick Road Baltimore, MD 21228 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1 ars **Physician** Dementia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to finite diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a dovisequence of): Examiner burial-transit and Due to (or as a consequence of): the attending physician P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year detached for in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? iis certificate has been signed director, page 2 should be de Division of Vital Records, þ 2 No 3 Probably 4 □Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 Z No 1 Yes Hospital or Attanding Physician: 24 hours after death. Funeral Diractor: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Oescribe how injury occurred funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No М 6 ☐ Could not be 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 T Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifle 2 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Catusville marich Cheris Lans 7511 And 711

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JUN 0 8 2004

32. Registrar's Signature

				State of Maryland / Dep		•	
_			1 - For State Registrar		ertificate of Death	Reg. M	211111 18077
	Physic /Medi	cal	Decedent's Name (First, Middle, Last) Horace 4a, Facility Name (If not institution, give s	Lee	14.00	June 5	Pay Year 3. Time of Death 2004 8.55 A M
	Examir	ner	Caton Manor	Genesis Elderca	4b. City, Town, or Location of Death	1	c. County of Death
	Funeral Director		5. Social Security Number 227-18-7087 Usual Residence of Decedent	M 2□ F 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Sept. 20,	9. Birthplace (State or Foreign Country) 923 VITGINIA
	nyland how		10a. State 10b. County	10c. City, Town or L			10d. Inside City Limits
	the Ma	ecto	MP NIA 10e. Street and Number	Baltime			1 PYes 2 No
	h with	al Dir	3330 Wilkens 1	ave.	10f. Zip Code 21229	- 4	Citizen of What Country?
980	be filed within 72 hours after death with the Maryland nat Hygiene. sd other than "natural", or flems 23a or 28a-1 show event, the Modical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 PNo If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc. Specify: Black
2-0	72 ho	eted	15. Decedent's Educ (Specify only highest grade	cation 16a. Dece	edent's Usual Occupation a kind of work done during most of won DO NOT use retired)	king 16b.	Kind of Business/Industry
21215-0036	filed within Hygiene. Ither than Int, I've Mo	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Ster man	F	Fishing
		Be	17, Father's Name (First, Middle, Last)			ne (First, Middle, Maide	en Sumame)
Maryland	2 should be and Mental is marked c	2	19a, Informant's Name/Relationship (Tyx	ne Print) 19h Maili	ing Address (Street and Number or Ru.	ne Hene	GORSON
	27 E		Gloria Jackson	niece 3114	Howard PK.	Balto, n	1D 21207
Baltimore,	permit. Pages 1 al Department of Hea Importent: If Item sny injury or othe once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	anioval from State	osition (Name of matory or other place)	Date 20c.	Location - City or Town, State
altin	permit. Pages Department of Importent: If II any injury or conce.		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Sureral Service Livense	METO	2. Name and Address of Facility	24 Ca.	tonsville, mo
8	perm Depa Impo sny ii		Jany (1-11)	and &	My P. March FlH &	70 Fredhilt	on Poss Batto, ind 2122
	Physician /Medical		23a. Part 1. Eoter the disease, or complic shock, or heart failure. List only on Immediate Cuse (Final disease or condition resulting in death)	Pheun	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Examiner		Sequentially list conditions	Due to (or as a consequence of):	he DNState	(Orcin.	ma
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
0,	e be executed /sician and e burial-transit		that initiated events 'c. resulting in death) Last	Due to (or as a consequence of):			
68760,	# × •	dical	d.				
.O. Box (The law requires that the death certificate to the has been signed by the attending physic age 2 should be detached for use as the tops.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Q	w requires that been signed by should be deta	þ	Part II. Other significant conditions cont	ributing to death but not resulting in the u M タ n かん	nderlying cause given in Part I.		use contribute to the cause of death?
al Records,	(Q CZ	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2₺ No
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	Other	h (Check only one)	
Division of	ng Phy fter the	on: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time o Injury	7	ome 5 Residence 28d. Describe how inju	
isio	uttendi death. ctor: A y the fu	Icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, str	M 1 ☐ Yes 2 ☐ No	20f Location (Ctreats	ad Number of Device
οį	tel or A s after el Dire ed in by	Certification;	4 Homicide determined	building, etc. (Specify)	eet, ractory, office	City or Town, Stat	nd Number or Rural Route Number, e)
	To the Hospital or Attending Physicien: within 24 hours alter death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examina	cian: To the best of my knowledge, deatler: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cause(s red at the time, date an	s) and manner as stated. d place, and due to the cause(s)
	To the within come le	Me	29b. Signature and fifte of certifier	Endy Physie.	29c. License number 29c. D 5 3 6 8	12 Ju	ate signed (Month, Day, Year)
			30. Name and address of person who com	npleted cause of death (Item 23a) (Type,	Print)	BIUL PU	3 Botton 2123
	Sta Registr		31. Date filed (Month, Day, Year) UN 0 8 2004	32. Registrar's Signature	land !		

			1 - For State Registrar	State of Ma		partment of Fertificate of	lealth and M Death		giene2004	18078
	Physici	an	1. Decedent's Name (First, Midd	e, Last)	1	1		2. Date of Dear	Day Year	3. Time of Death
}	/Medic		4a. Facility Name (If not institution	n, give street and number)	11)	-1.55av	r Location of Death	" lay	4c. County of Dea	
	LXaiiiii	Ci	The John.	Hopkins	Hospita	1 3	altimor	e C'ti	N/A	
	Funeral		5. Social Security Number	6. Sex 7. Ag 1 ☐ M 2 🔀 F	e (In yrs. last birthda I. I. Yrs.	Months Days		8. Date of Birth (Month, Day		thplace (State or Foreign ountry)
	Director		162-52-4575 Usuel Residence of Decedent		44 115.			8/16/19	59 PEN	NSYLVANIA
	anylan ahow	_	10a. State 10b. County		10c. City, Town or		,			10d. Inside City Limits
	the Mg	ecto	PA	YORK	SPRII	NGETTSBURY			0g. Citizen of What C	1 ☐ Yes 2 ☐ XNo
	3a or	i	3445 CRANMERE	LANE		174	+02		USA	ountry !
	eme 2	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No-	14. Race - Am Black, Whi	
36	72 hours after death with the Maryland natural', or Iteme 23a or 28e-f ehow Itsal Evand at must be notified at	by Fu	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	ned 1 □ Yes 2 □X	No	1 ☐ Yes 2 ☐XNo	Specify:	,	Specify:	WHITE
21215-0036	n 72 hours natural',	ted	15. Deceder	it's Education	16a. Dec	edent's Usual Occup	ation		16b. Kind of Business	
21	⊆ = ₹	Completed	Elementary/Secondary (0-12)	st grade completed) College (1-4or 5	i+) life.	DO NOT use retired	during most of working	ig		
	be filed with tal Hygiene d other the event, tree		17. Father's Name (First, Middle,	4 YEARS		reacher	18. Mother's Name	(First, Middle, I	EDUCATI Maiden Sumame)	ON_
Maryland	₹ 5 € €	To Be	MICHAEL MAROL	LA			DOLORES .			
lary	d 2 should the and Men 7 is marke traumatic		19a. Informant's Name/Relations			•			, City or Town, State,	Zip Code)
	1 an Heall em 2 ther	1	MICHAEL LISSAUE 20a. Method of Disposition	R HUS	BAND 344 20b. Place of Dis	45 CRANMER		ORK, PA	. 17402 20c. Location - City or	Town State
Baltimore,	0 0		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		cemetery, cr	ematory or other place PULCHE CEM	(8)			
altir	nit. artın ortsi injt.	ŀ	21. Signatury of Funeral Service		The second secon	22. Name and Addres			CHELTENHAM N FUNERAL	
ñ	Deg Find Sung		Heather	N- Huje	8	3521 LOCH	RAVEN BLV			286
			23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final	complications that caused only one cause on each li	the death. Do not e	nter the mode of dyin	g, such as cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. Due to (or as	a consequence of):	-comp	homa			Longth
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter the cause (Disease or injury	Due to (or as	a consequence of):					
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8760,	ate be ex hysician a	cai		d.						
9	h certifica anding ph use as ti	/Med	IF FEMALE:	23c. If yes, outcome	of programmy					
Вох	leath c attend	Physician/Med	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	,		23d. Date of de Month	livery Day Year
P.O.	at the de by the a tached	hysi	1 □ Yes 2 ☑ No 9 □ Unknown	9□ Unknown						
	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditi	ons contributing to death b	ut not resulting in the	underlying cause give	en in Part I.	23e. Did tob	oacco use contribute to es 2 No 3 □ Pr	o the cause of death?
Records,	The law retate has be page 2 she	Completed						24a. Was an autops perform	n 24b. Were as prior to death?	utopsy findings available completion of cause of
Vital	ician: Teatifica	Be	25. Was case referred to medica examiner?				26. Place of Death			
of	Physi rthis c ral dir	5	1 Yes 2 No	Hospital: 1 Inpatie		The second secon	4 Nursing Hom		nce 6 □Other (Spe	cify)
on	nding l tth. r: After e funer	ation	Natural 5 Pending	ng (Month, Da)	Year) Injury	Worl	k?` Yes 2 □No	DG. 2000/120 110	W injury coodinad	
Division	ist or Attanding Physician: s after death. l Director: After this certific ad in by the funeral director.	Certification:	3 Suicide 6 Could 4 Homicide determ		ury - At home, farm, s c. (Specify)	treet, factory, office	2	Bf. Location (Sti City or Town	reet and Number or Ri , State)	ural Route Number,
	To the Hospital or A within 24 hours after To the Funerel Dire completely filled in b	edical (29a. Certifier 1 Certifyin (Check only one)	ng Physician: To the best Examiner: On the basis of and planner sta	examination and/or i	ath occurred at the time	ne, date and place, at pinion, death occurre	nd due to the ca	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
)	within To the comp	¥	29b. Signature trouits of certific	A ,	nD	29c. License	5 - 000		papate signed (Mont	h, Day, Year) 2004
	J.		30. Name and address of person	who completed cause of d		4 11	ale's 1 m	w> . 1 /	Bultimo	re MD
	Sta	te	31. Date filed (Month, Day, Year,	32. Registra	ar's Signature	ohns Ho	7~75 6U	JAU	volte Stree	J 21287
	Registr		: IIIN 0 8 21	me Serve	e 4	1				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2001 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 03 PEGGY 06 Α. LEWIS 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number 4c. County of Deeth BALTIMORE 705 6. SAY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) APRIL 2, 1952 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1□ M 21 F Days 456-92-0735 52 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1F1Yes 2□No RANDALLSTOWN BALTIMORE 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 9627 MENDOZA ROAD 21133 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) POLICE OFFICER LAW ENFORCEMENT 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAMES DOUGLAS MOORE, SR. ELLA MARIE MOORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RANDALLSTOWN, MARYLAND 9627 MENDOZA RD. 21133 KAREEM LEWIS/SON 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) CEDAR HILL MEMORIAL 6/12/04 FT. WORTH, TX 22. Name and Address of Fecility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licensee 1701-31 LAURENS ST. BALTIMORE, MARYLAND 21217 23a. Pert1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) 4 month wronic Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed?

Physician /Medical Examiner

or Attending Physician: The lew requires that the death certificate be executed

hes

this

To the Hospital or Attending within 24 hours after death.
To the Funerel Director: Afte completely filled in by the fun.

P.O. Box 68760.

Division of Vital Records,

Examiner

Physician/Medical

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Completed

Be

Medical

permit. Peges 1 and 2 should be file.
Department of Heelth and Mentel Hy, important: If item 27 is marked other any injury or other contracts.

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

Be

Funeral

Director

tem 27 ie marked other than "natural", or items 23a or 28a-f ehow other traumatic event, the Medical Examinar must be notified at

Baltimore, Maryland 21215-0020

4882

30

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) 29b. Signeture and title of certifier

27. Menner of Deeth

1 Naturel

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29c. License number

29d. Date signed (Month, Day, Year) June, 4

neutaur 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) CHARUMEHTA, MD

5 Pending

investigetion 6 Could not be determined

601, South charles street; Baltimore, MD21230

State Registrar 31. Date filed (Month, Day, Year)

JUN 0 8 2004

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** MCKINLEY Ам MILES JUN 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 212 34-0699 15€M 2□ F Days Hours Min. MD Director 25 Usual Residence of Decedent 10a State 10c. City, Town or Location Show 10d. Inside City Limits itam 27 is marked other than "naturel", or items 23a or 28a-f show other treumatic event. It a Mudical Example must be notified at MD FT. WASHINGTON PRINCE GEORGES Director 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3112 Rose VALLEY DRIVE 20744 U.S.A. death Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MINISTRY CLERGY 12th grade 6 years 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill treent of Health and Mental Hitant: If itam 27 is marked off McKINLey MAMIE ALICE MILES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) I. MILES MAMIE Rose VALLEY DRIVE FT, WASH, MD 3112 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Huportant: If its sny injury or ot once. cemetery, crematory or other place)
ARLINGTON NATIONAL 1 Surial 2 □ Cremation 3 □ Removal from State *4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. CREENE FUNERAL SERVICES SISI BALTIMORE NATIONAL PIKE BALTO IND 21229 ang 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MULTIPLE MYELOMA disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury Jua to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached ☐Yes 2☐No 9 Unknown 9 - Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan certificate has ormeg? 21X No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Xnpatient 1 ☐ Yes 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Medical Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 XNatural 2 Accident death. 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the ! and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 06/07/04 0101235157 (VA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BRIAN D. SUSI MC USN BETHESDA MD 20889-5600 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

Physic	ian	1. Decedent's Name (First, Middle,	State of M. State				2. Date of Dea Month	th Day Year	3. Time of Death
/Med	ical	4a. Fecility Name (If not institution,		-,,,-	4h City Tayan	Lacada at Bank	Much	13,0009	4,401
Exami	ner	Bon Seco	//	//	4b. City, Town, or	Finor C		4c. County of Death	
Funeral Director		215-60-1940	6. Sex 7. Ag	e (In yrs. last birthda 51 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Mar. 14	y Yeer) 9. Birthy County 1952 Vir	olace (State or Forei ntry) ginia
Mow H		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limi
liffied	Director	M.D. N/	Α	Baltimo	ore				13∑ Yes 2 ☐ I
a or 2 bend	Dire	10e. Street and Number 1543 Smallwood	d Street		10f. Zip Code	216	1	log. Citizen of What Cour	ntry?
ms 23	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13	3. Was Decedent of His If Yes, specify Cubar		city Yes or No-	U.S.A.	can Indian,
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and Mental Hygiene. Is marked other than aumatic event, the Mental Men	To Be	James Burrel	.1		(18. Mother's Name Gertrude	Randa	all	
5 5 5 E		19a. Informant's Name/Relationshi Maurice M. Ma						r, City or Town, State, Zip Dre, M.D. 2	
0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	3 □Removal from State	20b. Place of Disp cemetery, cri	oosition (Name of ematory or other place)	ate	20c. Location - City or To	own, Stete
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Departr Imports any inju		21. Signature of Funeral Service Li	censee	V V	22. Name and Address	wat	ter Fu	neral Hom	e Inc.
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Physici	10	Self State of State of State of Registrar 1. Decedent's Name (First, Middle, Last)			2. Date of Month		3. Time of Deat
/Medic		DANIELLE MARIE MEISEL			June		853 a
Examin	ier	4a. Facility Name (If not institution, give street and num 31 Harwood Drive	nber)	4b. City, Town, or Loca White Ma		4c. County of Dea Baltimo	
Funeral Director		5. Social Security Number 6. Sex 1 M XXF 218~92~7116 ** 1 M XXF Usual Residence of Decedent	7. Age (In yrs. last birthday 39 Yrs.		urs Min. 8. Date of I	9. Bi	rthplace (State or Fore country) aryland
Maryland a-f ahow ilied al	tor	10a. State 10b. County Maryland Baltimore	10c. City, Town or L	ocation altimore Cou	inty		10d. Inside City Lin
h with the	Funeral Director	10e. Street and Number 31 Hardwood Drive		10f. Zip Code 212	237	10g. Citizen of What C	ountry?
iled within 72 hours after death with the Maryland Hygiene. Inflar than "natural", or Itams 23& or 28&-f ahow ant, the Madical Examiner must be notified a	b	11. Marital Status 1 Never Married 3 Widowed 4 Divorced 12. Was Decernated Form 1 Yes Sire Yes, Give Year or Da	2√Z No e	Was Decedent of Hispani If Yes, specify Cuban, Me	ic Origin? (Specify Yes or ixican, Puerto Rican, etc.)	No- 14. Race - Am Black, Wh Specify: Wh	ite, etc.
J within 72 hor piene. r than "natura The Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	-40f 5+}	edent's Usual Occupation a kind of work done during DO NOT use retired)	most of working	16b. Kind of Business	s/Industry
a = 0 %	Be	12 yrs 4 yrs. 17. Father's Name (First, Middle, Last) Daniel Coles	Но		Mother's Name (First, Midd Helen Raynor		ng~Own Hor
d 2 should be h and Mental 7 Ia marked o traumatic eve	Ը	19a. Informant's Name/Relationship (Type, Print) Scott J. Meisel (Husband		ing Address (Street and N	umber or Rural Route Num ve Baltimore,	nber, City or Town, State,	Zip Code)
permit. Pages 1 and 2 should b Department of Health and Ments Important: If itam 27 is marked any injury or other traumatic sonce.		20a. Method of Disposition 1 ☐ Burial XX Cremation 3 ☐ Removal from S	20b. Place of Disp	osition (Name of of other place) ematory Inc.	Date	20c. Location - City or Baltimore,	
permit. P Departme Importan any injury once.		. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Incense		2. Name and Address of F Lassahn Fun	i		
Physician /Medical Examiner Physician and P	Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	or as a consequence of): or as a consequence of): or as a consequence of):	y Artery Dis	section	allest,	Approximate Interval Between Onset and Deat
er sys	by Physiclan/Medical I	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ant at time of death 5(wn	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	livery Day Year
equires ina ven signed l ould be det		Part II. Other significant conditions contributing to dea	ath but not resulting in the u	ınderlying cause given in F		l tobacco use contribute to] Yes 2 ☐ No 3 ☐ Pi	o the cause of death robably 4 Inkno
te has be	Completed				per 1 X Yes	opsy prior to death? 2 No 1 ** es	utopsy findings availa completion of cause 2 No
ifica or, p	To Be	25. Was case referred to medical examiner? 1 \$\overline{\text{T}}\$ Yes 2 \(\) No 1 \(\overline{\text{T}}\$ No \) 27. Manner of Death 1 \(\overline{\text{T}}\$ Natural 5 \(\overline{\text{Pending}} \) Pending 2 \(\overline{\text{Accident}} \) Accident	patient 2 ER/Outpatie f Injury n, Day Year) 28b. Time of Injury	nt 3 DOA Other: 4[ocity) at scer
anding Prysician: bath. br. After this certificate funeral director, p	atlon			reet factory office	28f. Location	(Street and Number or Ri	ural Route Number,
trial or Attaining Prysician: The law requires that the death certifics is after death. This is a second of the second of the attending phase to be the funeral director, page 2 should be detached for use as the funeral director, page 2.	Certification;	3 Suicide 6 Could not be determined 28e. Place of building	of Injury - At home, farm, st g, etc. <i>(Specify)</i>		City or 1	, 0.11,0/	
o the hours after death within 2 hours after death within 24 hours after death within 24 hours after death a within 24 hours after death a completely filled in by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be	Medical Certification	dotomicod 288, Place C	g, etc. (Specify) best of my knowledge, deals of examination and/or in	h occurred at the time, dat	e and place, and due to the	a cause(s) and manner as	e to the cause(s)

			State of Ma	aryland / Depa	artment of Health and			1000
			1 - State Registrar		rtificate of Death	Reg. N	2000	1808
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month D	ay Year	3. Time of Death
	/Media		GORDON C. MCNAMARA			JUNE 02		5:51 P ^M
	Examin	er	4a. Facility Name (If not institution, give street and number) MARINER HEALTH OF FOREST H	ттт	4b. City, Town, or Location of De FOREST HILL	eath 4	c. County of Death HARFORD	
	Funeral			је (In yrs. last birthday)	If Under 1 Year If Under 24 H	rs. 8. Date of Birth	9 Birthol	ace (State or Foreign
	Director		216-14-8922 12M 20F	80 Yrs.	Months Days Hours M	in. March 28 Kg	24 Mari	Mand
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10	d. Inside City Limits
	Maryl -1 sho	to	Mn Hassand	Minade	\s i			1 ☐ Yes 2 No
	h the	lrec	10e. Street and Number	, Andread	10f. Zip Code	10g. C	itizen of What Count	ry?
	23a c	Funeral Director	3105 White Oak ior #x	7	21009		USA	
	ltems	nue	11. Marital Status 12. Was Decedent Armed Forces?		Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - America Black, White, e	
336	urs aft	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes. 2 ☐ 1 ☐ Yes. Give Year or Dates:	40	1 ☐ Yes 2 No Specify:		Specify: Whi	de
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-1 show ite Mudical Examiner much be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during most of w	modeling 16b.	Kind of Business/Ind	ustry
2	Mithin ne.	mple	Elementary/Secondary (0-12) College (1-4or 5	life.	DO NOT use retired)	G/	richaire	incl
	filed v Hygie other t		17. Father's Name (First, Middle, Last)	fle	18. Mother's N	lame (First, Middle, Maide	n Sumame) .	.00
an	id be lental ked o	To Be	William T. McKamapa	2 50	Edi	UL DODO	Endos	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show mithy or other traumatic event, the Madical Examiner must be notified at ance.	_	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number or	Rural Route Number, City	or Town, State, Zip	Code)
	and 2 ealth m 27 h		Kathloon Berige - dan	Week 114.	BOXYNOLN Rd. +	Abingdon 1	10 2100)4
Baltimore,	Pages 1 nent of H int: if ite iry or ott		20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, cren	natory or other place) Bell Ju	Date 20c.	ocation - City or Tov	vn, State
ᄩ	artmer artmer ortant injury		* 4 □ Donation * 5 □ Other (Specify) 21. Signature of Puneral Service Licensee 1 1 1	CVanstan	P. Name and Address of Facility	2004 YOF	est Hell 1	MULYICINO
Ba	permit. Departr Imports eny inj		Koi Ha Ha Jolly	- 2	Llewant De	FORMA ILIO	WD 210	50
<u>E</u>	5		23a Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	the death. Do not ent	er the mode of dying, such as card	iac or respiratory arrest,	10110	Approximate Interval Between
>	Physician		Immediate Cause (Final disease or condition	of the Co	olon			Onset and Death
JE.	/Medical Examiner		resulting in death) Due to (or as	nsequence of):	. i di di	1 011	,	
Н		er	Sequentially list conditions, Lary, leaving to immediate cause. Enter Underlying	a consequence of):	sis with Phe	ent Effus	ion i	months
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events					
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6876	physic physic the b	edical	d					
ox 6	eath certific attending pl	√/Me	IF FEMALE: 23c. If yes, outcome 23c. If yes, outcome				23d. Date of deliver	v
. Box	death e atte	Physician/M	in the past 12 months?		Ectopic pregnancy Other (specify)			Day Year
P.O.	that the de sed by the a detached t	Phys	9 Unknown					
	g g	þ	Part II. Dther significant conditions contributing to death be	ut not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the	bly 4 Unknown
Sor	w require	letec						
Records,	The law ate has page 2 s	Completed				24a. Was an autopsy performed?	prior to com death?	sy findings available pletion of cause of
_		0	25. Was case referred to medical		26. Place of D	1 Yes 2 N eath Check on one	1 ☐ Yes 2	P□ No
>	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatien	Out of the last of	Home 5 Residence	6 ☐Other (Specify)	
Division of	Attending Physicien: If death. Sector: After this certification in the funeral director.		27. Manner of Death 1 Avatural 5 □ Pending 28a. Date of Injur (Month, Da)	ry 28b. Time of Injury	Work?	28d. Describe how inju	iry occurred	
Sic	or Attend after death Director: /	licat	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Inju	ury - At home, farm, stre	M 1 Yes 2 No	28f. Location (Street a	nd Number or Rumi	Pouto Number
<u>></u>	al or A after I Dire	Certification:	4 Homicide determined 238. Flace of Injury	c. (Specify)	eer, ractory, onice	City or Town, Star	e)	noute Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one) 12 Certifying Physician: To the best of the property of the p	of my knowledge, death	n occurred at the time, date and pla	ce, and due to the cause(s	and manner as sta	ted.
	the H	Medi	one) and manner sta	ited.	29c. License number			
	To To		250. Signature and this of cartinal	MD	D 00 56 60	7 7	ate signed (Month, D	200L
	n	1	30. Name and address of person who completed cause of do	eath (Item 23a) (Type,	D005660; Print) 602. S. A7Wo			7
			JOSEPH ANGELO 7	4106.	602. S. ATWS	OD Rd, BL	LAIR 1	21014
	Sta Registr		11111 0 0 0001	ar's Signature	doars			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) arrow 349 N **Physician** incolv Ma /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner Baltimore VA Medica timore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthdey) 5. Social Security Number 6. Sex **Funeral** Months 1□ M 2□ F 242-42-4793 Director 1928 N. Carolina Usual Residence of Decedent parmit. Peges 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itams 23e or 28e-f show any Injury or other traumatic event, the Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State Baltimore 1 ⊋Yes 2 □ No N/AMaryland Director 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street end Number 21212 USA 5615 Midwood Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No 1 9 5 0 -1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1□ Yes 2□ No Specify: Specify: Black δ 3 Widowed 4 Divorced Year or Dates: 1954 Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) New York City College (1-4or 5+) Elementary/Secondary (0-12) Police Officer Police Dept. Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Mattie Johnson Theodore Marrow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5615 Midwood Ave Baltimore, Maryland 21212 Jessen Marrow/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5/29704 L□ Burial 2 □ Cremation 3 □ Removal from State Ch. Cem. Enfield, N. Carolina Pleasant Hill Bapt. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licens 5240 Reisterstown Road Baltimore, Md 21215 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, show, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of Physician/Medical Examiner To the Hospital or Attanding Physician: The law requiras that the death certificate be assecuted within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attanding physician end completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) P.O. Box 68760. Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Division of Vital Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1 ☐ Yes 2 No 1L Yas 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 Certification: To 12 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 5 ☐ Pending investigetion 1 Neturel Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner es stated. Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 16 Bohim MI 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Registrar

State

Stephanie Y. Borum,

JUN 0 8 2004

31. Date filed (Month, Day, Year)

ORIGINAL

N. GREEN

32. Registrer's Signeture

3			For State Registrar	State o	f Maryland	•	artment rtificate			and M	,	giene Reg. No.?	00		9095
	Physic		Decedent's Name (First, Mi Thomas	iddle, Last)	M	cKnic	aht				2. Date of De Month	Day	Yea	3.	Time of Death
	/Medi Examir		4a. Facility Name (If not institu	tion, give street and nur kins Hospita	n <i>ber</i>)		4b. City, To		Location o		May 3		ounty of Do Na	eath	1050 a ^M
	Funeral Director		5. Social Security Number 217–68–1855	1 X M 2□ F	7. Age (<i>In yr</i> s. <i>las</i>)	vrs.	If Under 1 Months I	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	y, Year)	9. 8	Birthplace Country)	(State or Foreign
	death with the Maryland ms 23e or 28e-f show	or	Usual Residence of Decedent 10a. State 10b. Cou Md.		10c. City, T	own or Lo									side City Limits X Yes 2 □ No
	ith the h	Director	10e. Street and Number				10f. Zip C	ode				10g. Citize	n of What		
36	s after , or Ite	by Funeral	5825 The Alm 11. Marital Status 1 Never Married 2 X N 3 Widowed 4 Divord	12. Was Dece Armed Fo 1 Yes If Yes Giv	2 [X No 'e	1				gin? (Spec , Puerto P	rify Yes or No lican, etc.)	- 14	USA Race - Ar Black, W	merican Inchite, etc.	
Maryland 21215-0036	a 20	Completed b	15. Dece (Specify only hig Elementary/Secondary (0-1)	dent's Education thest grade completed)	1	(Give life.	dent's Usual (kind of work DO NOT use	done du retired)	ıring most					ss/Industry	,
1d 2	is 1 and 2 should be filed within of Health and Mental Hygiene. item 27 Is marked other than other traumatic event, Ite Ms	Be Co	10th grade 17. Father's Name (First, Midd	fle, Last)		Sur	perviso				CE (First, Middle,			vers	ity
ylar	ould be Menta narked natic ev	ToB	Abbie		McKni				Sus		Μ.		illia		
	nd 2 st alth and 27 Is n ir traun		19a. Informant's Name/Relation Susie McKnig		her		-				Route Number) 031 Apt 9
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other		Jiaio	e of Dispo etery, cren	sition (Name natory or othe Mem. I	of er place,	,	Da 5-7-0	te	20c. Loca		or Town, S	
Balti	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Serv	dus Wo		22	Name and	Address	of Facility	/	Baltim 1101 E	ore,	Md.	21202	2
x 68760,	death certificate be executed Exam e attending physician and id for use as the burial-transit	/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last IF FEMALE:	b. Due to (c) c. Due to (d) d.	or as a consequent or as a consequent or as a consequent or as a consequent come of pregnancy	ce of):		ine	. .						
.O. Box	by the	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live bi	inth 2 Fetal deant at time of death	ath 3□	Ectopic pregi Other (speci					230	Date of d	elivery Day	Year
Records, P	w requires that the been signed by the should be detache	by	Part II. Other significant cond	litions contributing to de	ath but not resultin	g in the ur	derlying caus	se given	in Part I.		23e. Did to	-1			se of death?
	The law ate has b page 2 st	e Completed	25. Was case referred to med							_		sy med? 2 🗆 No	4b. Were a prior to death? 1 X Ye	completio	idings available on of cause of
of Vital	ys di	To Be	examiner? 1 XYes 2 No	Hospital:	npatient 2 ER/	Outpatien	3€ DOA	Other			Check on or 5 ☐ Resid		Other (Sp	ecify)	
o uo	ling After fune	tion:	27. Manner of Death 1 Natural 5 Pen	ading 28a. Date of Month	of Injury h, Day Year)	b. Time of Injury	28c.	Injury a Work? 1 🗌 Ye	\vee		d. Describe h	ow injury o	curred	1	
Division	or Atten fter deal director. In by the	Certification;	3 ☐ Suicide 6 ☐ Cou	lid not be 28e, Place	of Injury - At home ng, etc. (Specify)	, farm, stre			2 2 3 4 1		f. Location (S City or Town	treet and N n, State) 5	MISISO JIMBOT OF F 25710 MB	Nural Route	e Number, DA
	e Hospitel 24 hours a e Funeral D etely filled i	edical	29a. Certifier 1 Certification Check only one) 2 Medic	ying Physicien: To the sel Exeminer: On the ba and mann	isis of examination	dge, death and/or inv	occurred at t estigation, in	he time, my opir	, date and nion, death	place, an occurred	d due to the c at the time, d	ause(s) and late and pla	l manner a	s stated.	ause(s)
	To the within 2 To the complet	Me	29b. Signature and title of cert	ifier & M	14			icense r			2	9d. Date si May	gned <i>(Mor</i>	-	'ear)
	6		30. Name and address of pers	110 1.6.	of death (Item 23	a) (Type, F	111	Pen	n Sti	reet,	Balti	more,	Mary	land	21201
2	Sta Registr		31. Date filed (Month, Day, Ye	a <i>r</i>) 32. R	distrar's Signature	B	Soo	o Marie	,						ii.

			1 - State Registrar		epartment of Health Certificate of Death		Hygiene Reg. No.) () i,	18086
	Physici	an	1. Decedent's Name (First, Middle, Last) Jack L. Mc	Cauley		2. Date of Month	of Death Day	Year	3. Time of Death
A	/Medic Examir		4a. Facility Name (If not institution, give street a		4b. City, Town, or Location	Jun of Death		04 nty of Death	12:36A M
			4626 Keswick Road 5. Social Security Number 6. Sex	7. Age (In yrs. last birthd	Baltimo:		of Right	N/A	-la (O
	Funeral Director		220-24-2228 XXM 28		Months Days Hours	Min. (Month	of Birth n, Day, Year) 4-1930	Cou	place (State or Foreign intry) ryland
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits
	8e-f sk	Director	Maryland N/A	Ba1	timore				M∑Yes 2 No
	3e or 2	Dire	10e. Street and Number 4626 Keswick Road		10f. Zip Code 21211		10g. Citizen o	of What Cou ISA	intry?
36	be filed within 72 hours after death with the Maryland ital Hygiene. so other then "naturel", or Items 23e or 28e-1 show event, the Medical Examiner must be notified at	by Funerai	11. Marital Status 12. Wa. 1 □ Never Married 2 Married 1	red Forces? Yes 2 ☐ No	13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica	n, Puerto Rican, etc	r No- 14. R	lace - Ameri lack, White,	, etc.
21215-0036	72 hour	ted b	15. Decedent's Education (Specify only highest grade comp.	es, Give tr or Dates: Korea	ecedent's Usual Occupation		16b. Kind of	- W J	hite
121	within 7 ene. then "n	Completed	Elementary/Secondary (0-12) Coll	lege (1-4or 5+)	ive kind of work done during mos e. DO NOT use retired) ehouse employ		APD	C	C +
nd 2	be filed within tal Hygiene. d other then event, the Me	Be Co	9 t h 17. Father's Name (First, Middle, Last)	wai		er's Name (First, Mi	ddle, Maiden Sum	ame)	ery Store
Maryland	should be nd Mental marked c	70	William McCauley 19a. Informant's Name/Relationship (<i>Type, Prir</i>	405 14		Mary Lo			
	nd 2 :: alth ar 27 Is r treu		Nancy McCauley		ailing Address (Street and Numb 26 Keswick Ro		timore.		21211
Baltimore,	di O		20a. Method of Disposition XXBurial 2 Cremation 3 Removal	from State cemetery,	sposition (Name of crematory or other place)	Date	20c. Location	n - City or To	own, State
atir	- 돈 없 글		* 4 □ Donation 5 □ Other (Specify) 21. Signature 1 Fineral Service Licens	1	ose Cemetery 22. Name and Address of Facili				sylvania
ä	permi Depa Impo eny is		* Kerry to lay	Denbe	Burgee-Henss- 3631 Falls Ro	-Seitz F oad Bal	uneral timore.	Home,	Inc.
	Pnysician		23a. Pan Enter the disease, or complications shock, or heart failure. List only one caus immediate Cause (Final	that caused the death. Do not e on each line.	enter the mode of dying, such as	taidiac or respirato	ry arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	ue to (or as a consequence of):	Inonary o	disease			7/5
	LAMITATES	e	Sequentially list conditions, if any, leading to immediate D	ue to (or as a consequence of):					
	scuted ind transit	Examiner	Cause (Disease or injury that initiated events c.						
58760,	icate be executed physician and s the burial-transit	dicai Ex	b d	ue to (or as a consequence of):					
_		a)	IF FEMALE:	-					
P.O. Box	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Date of delive Month	ery Day Year
	nrequires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing doubletes multiple	e i	e underlying cause given in Part I		Did tobacco use co ☐ Yes 2 ☐ No		he cause of death?
al Records,	i: The law r icate has be r, page 2 sh	Completed		,	,	a	utopsy erformed?	were auto prior to co death? 1 \(\text{Yes}	psy findings available mpletion of cause of 2 No
f Vital	ysicien: The is certificate h director, page	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/Outpa	Other	of Death (Check or		ther (Specil	v)
on of	ding Ph h. After th funeral	ion; T	1 ☑Natural 5 ☐ Pending	Date of Injury (Month, Day Year) 28b. Time Injury	e of 28c. Injury at Work?	28d. Descri	ibe how injury occu		,,,
Division	if or Attend after death Director: .	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, building, etc. (Specify)	M 1 Yes 2	28f. Location	on (Street and Nurr Town, State)	nber or Rura	il Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director, to	edicai C	(Check only 2 Medical Examiner: On	To the best of my knowledge, de the basis of examination and/or I manner stated.	eath occurred at the time, date an r investigation, in my opinion, dea	d place, and due to th occurred at the tir	the cause(s) and n	nanner as st	ated. the cause(s)
	To the Vithing Comp.	ž	29b. Signarare and title of certifier		29c. License number		29d. Date sign		Day, Year)
,	10		30. Name and address of person who completed		00059) De, Print)		6	-2-09	
			31. Date filed (Month, Day, Year)	7 2 W. Y	10th St Bal	Himore 1	no 212	(/	
2	Sta Registr		JUN 0 8 2004	22 by	Soaks				

			for State	State of Ma	ryland	/ Depa	artment of H	lealth and	d Mental Hy	/giene	2004	18087
		-	Registrar 1. Decedent's Name (First, Middle, Las)		Cei	rtificate of l	Jeath	2. Date of D	Reg. No.		3. Time of Death
	Physici		Doris M. Marshall						Month	29 ^{Day}	2004	11:10 P M
	/Medio Examir		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of De			County of Death	11.10 P
			Mariner Health of	Forest Hi	11		Forest H			Ha	rford	
	Funeral		5. Social Security Number 6. Sec. 218-40-0323	7 M OF YE	(In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days		in. (Month. D	rth ay, Year)	Cour	
	Director		Usual Residence of Decedent	9	0				Jan. 1	/ , 19	08 Mary	land
	tryland thow	_	10a. State 10b. County		10c. City, T	own or Lo	cation				1	0d. Inside City Limits
	he Ma 18a-f s	Director	MD Harford		Fores	t Hil						1 ☐ Yes 2 ☐ No
	th with t	al Dir	10e. Street and Number 109 Forest Valley	Drive			10f. Zip Code 21050				zen of What Coun	try?
36	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show Alcal Exscrimer coust be rectified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:			Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 █ No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or N erto Rican, etc.)		14. Race - Americ Black, White, Specify: Wh	etc.
9-10	72 hours "naturel", ulcal Ex		15. Decedent's Ed		1	6a. Deced	ient's Usual Occupa	ation		16b. Kir	nd of Business/Inc	
21215-0036	within ane. than "	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5-		iife. ا Omema	kind of work done of DO NOT use retired ker	uring most of i	working	Own	Home	
b	filed Hyg othe	Be C	17. Father's Name (First, Middle, Last)					18. Mother's N	lame (First, Middle			
Maryland		To E	Goldsborough J	hnson				Lena	Ruark			
Mar	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic	a i	19a. Informant's Name/Relationship (T. Doris M. Robinson				g Address (Street a					
	s 1 and 3 f Health item 27 other tra	1	20a. Method of Disposition	/ daught	20b. Place	e of Dispo	axon Hill sition (Name of		, LOCKEYS		e, MD 21 cation - City or To	
E O	Pages nent of int: If it iry or o		1 Burial Cremation 3 II			•	natory or other place Memorial	1	4/04		ville, M	
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		21. Signature of Funeral Service Licens		11.01.0		. Name and Addres		17 04		50 York	
	207 2 2		Pety	ling			ck Towsor				wson, MD	21204
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line	the death. L e.		1), such as card	iac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a			elembra					
	Examiner		Sequentially list conditions,	,								
	ad sit	ılner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequen	ce of):						
	icate be executed physicien and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequen	ce of):						
68760,	icate be execut physicien and s the burial-trar	edical E		1								
_			IF FEMALE:					_				
P.O. Box	thet the death certifued by the attending detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	☐ Fetal de	ath 3□	Ectopic pregnancy Other (specify)			23	3d. Date of deliver Month	y Day Year
of Vital Records, P	8 76 8	by	Part II. Other significant conditions co	ntributing to death bu	t not resultin	g in the ur	derlying cause give	n in Part I.			se contribute to the	(
SCO	aw require as been sig 2 should b	Completed							24a. Was		24b. Were autop	sy findings available
E	The ate h page	Com							auto perfo	rmed?	prior to com death? 1 ☐ Yes	pletion of cause of ≳Cl No
/ita	Physicien: The this certificate har al director, page	Be	25. Was case referred to medical examiner?	L9-1					eath (Check only o	one)		
of	Physic this cral dir	.T	1 Yes 2 No	lospital: 1 Inpatien		Outpatient	3 □ DOA Othe	r. 4 Nursing	Home 5 Resi	dence 6	Other (Specify,	46
o	fter fre	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year)	Injury	28c. Injury Work M 1 \(\sum Y	at ? ′es 2 □ No	28d. Describe	now injury	occurred	
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	ry - At home, (Specify)	, farm, stre	et, factory, office		28f. Location (Street and vn, State)	Number or Rural	Route Number,
_	Hospital	edical C	Check only 2 Medical Exami	sician: To the best of	my knowled	dge, death	occurred at the time	e, date and pla	ce, and due to the	cause(s) a	and manner as sta	ted.
	o the ithin 2 o the l	Med	one) 29b. Signature and title of certifier	and manner state	ed.		29c. License				signed (Month, D	
}	⊢s⊢ŏ		Dans	5).				322			e 1,20	
	10		30. Name and address of person who co				Print)	1			-	
						. M	n=Phn	/ @	selair	mi	>	
	Sta Registr		JUN 0 8 2004	ate filed (Month, Day, Year) \$2. Registrar's Signature*								

			1- State of Maryland / Department of Health and No. Certificate of Death		giene 00	18088
	Physici /Medi	al	1. Decedent's Name (First, Middle, Last) John E. Miller 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	2. Date of Dea Month May	30, 2004	6:50 P ^M
	Examir Funeral Director	ier	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Stella Maris 5. Social Security Number 219-30-4370 6. Sex 1 Age (In yrs. last birthday) 1 Age (In yrs. last birthday)	8. Date of Birth (Month, Day April 2	r, Year)	
	e Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	Τρίτι Ζ	.5,1910	10d. Inside City Limits 1 ☐ Yes 2XXIo
	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, Ite Modical Examirst must be notified at	Funeral Director	2525 Pot Spring Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. Armed Forces)	pecify Yes or No-	U.S.A 14. Race - An Black, Wh	nerican Indian,
15-0036	n 72 hours aft "natural", or I potest Examil	þ	¹ 3X Widowed 4 □ Divorced If Ye's, Give 1943 − 1946 1 □ Yes 2 □ ANo Specify:	ing	Specify:	Mhite
Maryland 21215-0036	8 m m 8	Be Completed	17. Father's Name (First, Middle, Last) 18. Mother's Name		Medici Maiden Surname)	ine
	ss 1 and 2 should be feath and Menta item 27 is marked of other tranmatic events.	To	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural 315 Ivy Church Road T	al Route Numbel Timoniu m	, Maryland	21093
gaitimore,	permit. Pages 1 Department of H Important: If Ite any injury or ot		1 Burial 2 XCremation 3 Removal from State Donation 5 Other (Specify) Hilltop Service Corp. 6-3-2	2004	Towson Towson	Maryland Home, Inc.
D	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line. Immediate Cause (Final)	Towson,	Maryland	21204 Approximate Interval Between Onset and Death
	/Medical Examiner	ner	resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
8/60,	certificate be executed rding physician and use as the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d.			
O. Box 6	death certifi e attending id for use as	hysician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of de Month	elivery Day Year
cords, P	w requires that the been signed by th should be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?
vital Rec	The law ate has b page 2 st	e Completed	25. Was case referred to medical 26. Place of Death	24a. Was an autops perform	y prior to death? X No 1 Yes	utopsy findings available completion of cause of
DIVISION OF V	ling Phy n. After this funeral d	cation: To B	1 Yes 2 No	me 5 Reside	once 6 COther (Sperw injury occurred	HOSPICE
Š	spital or ours afte neral Dir filled in	al Certification;	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place a	City or Town	use(s) and manner a	cotated
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier 29c. License number	ed at the time, da	ate and place, and du	e to the cause(s)
0	20+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	MD 2100	6/1/	94
	Sta Registr		DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, 31. Date filed (Month, Day, Year) 32. Registrar's Signature	mu ∠109	13	

MAY 30, 2004

JOHN MILLER

			1 - For State Registrar	State of Marylan		artment of H			giene Reg. No. 2 (004	180	189
	Dhusisi		1. Decedent's Name (First, Middle, La	ast)				2. Date of Dea	ath	Year	3. Time of	Death
	Physici /Medic		Freda	Metaxas				June 2,	2004		1:50	Ам
	Examin	er	4a. Facility Name (If not institution, gi			4b. City, Town, or	Location of Dea	th		ty of Death		
			Greater Baltimor 5. Social Security Number 6.	e Medical Cente		Towson	If Under 24 Hrs	s. 8. Date of Birt		imore		
	Funeral Director			1 M 2 DF 92	Yrs.	Months Days	Hours Min		r, Year)	Coun	lace (State or try) Minor	-
	yland		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				1	0d. Inside Cit	y Limits
	e Mar	ctor	Maryland Baltin	nore P	arkvil	le					1 ☐ Yes	2 No
	ith th	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Coun	try?	
	s 23a	ra	8809 Alnwick Ro		0 100	2123			USA			
	Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 🗶 No	.5. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (n, Mexican, Puei	Specify Yes or No- rto Rican, etc.)	14. Ra	ace - Americ ack, White,		
36	urs af	by F	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□ Yes 2□ X No	Specify:		Spec	^{ify:} Whi	te .	
215-0036	within 72 hours after death with the Maryland iene. iene. r than "natural", or Items 23a or 28a-1 show	ted	15. Decedent's E		16a. Dece	dent's Usual Occupa	ation	atring .	16b. Kind of			
7	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done a DO NOT use retired,))	orking				
	e filed w If Hygier other th		17. Father's Name (First, Middle, Las	41	Home	Maker	40.14.15.1.11		Own H			
anc	Q 20 00	Be.		v orgiadis				me (First, Middle, Bano				
Maryland 2	2 should be and Menta is marked aumatic av	은	19a. Informant's Name/Relationship		19b. Mailir	ng Address (Street a				Unknou		
	12 h a 7 is		Diane Stavros / D			Alnwick R		Parkville				
altimore,	- £ a =		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other place	Ĭ.	Date	20c. Location			
Ĕ	Pages nent of I ant: If it		1 XBurial 2 □ Cremation 3 ('4 □ Donation 5 □ Other (Speci	_Removal from State	-	trios Cem		/04	Cub Hi	11. Ma	arvlano	±
alt	permit. Pag Department Important: t any injury o		21. Signature of Funded Service Lice		22	. Name and Addres	s of Facility				rk Roa	
n —	9959		land of.	/ay/11		uck Towso				owson,	Md.212	204
	Pnysician /Medical	SE W	23a. Part1. Enter the disaste, or coastock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	iplications that caused the death one cause on each line. a. Due to (or as a consequence of the consequenc	, then	er the mode of dying	g, such as cardia	c or respiratory arr	rest,		Approximate Interval Betw Onset and Do	eath
	Examiner		Sequentially list conditions	b. CHF -	rece	wrent					yn	
	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Otte to (or as a contequ	ianda (it)	- 1					di.	
	certiticate be executed ding physician and ise as the burial-transit	хап	that initiated events resulting in death) Last	c. Due (or as a consequ	ence of):	142				-	angs	
3/60	sician buris	calE	l l	6772	,							
289	iticate g phys as the	0		_ d.								
gog	leath certitic attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnal		Ectopic pregnancy			23d. D	ate of delive	у	
	0 0 0	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time of de		Other (specify)			М	onth	Day Ye	ear
J.	at the de d by the a etached	Phy	9 Unknown									
S,	w requires that the been signed by the should be detache	by	Part II. Other significant conditions				en in Part I.	23e. Dia toi	bacco use cor es 2 2 No		e cause of dea	
ecord	been should	etec	Dist.	tra raker plan		4 10		_				
Y,	The la ate has page 2	Completed	Pacin	raver flar	enu	u c		24a. Was a autops perform	ned?	prior to con death?	sy findings av ipletion of cau 2□ No	railable use of
Vital	Physician: this certitic ral director,	Be	25. Was case referred to medical examiner?	Hospital:		0,15-		ath (Check only on				
ō	Phy this ald	: To	1 Yes 2 No	i i≥ inpatient 2 ∐ i	ER/Outpatien 28b. Time of		4 Nursing F	dome 5 Reside				
	ding F th. Atter funer	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Work	? Yes 2□No	200. Describe III	ow injury occu	rrea		
UIVISION	al or Attanding F safter death. I Diractor: Atter d in by the funer.	Certification:	3 ☐ Suicide 6 ☐ Could not b	28e. Place of Injury - At ho	me, farm, str			28f. Location (St	reet and Num	ber or Rural	Route Numbe	er,
S	s afte	Sert	4 Homicide	building, etc. (Specify	")			City or Town	n, State)			
	To the Hospital or Atla within 24 hours after ded To tha Funaral Diracto completely tilled in by th	edical (29a. Certifier 1 Pertifying P	hysician: To the best of my know miner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the time restigation, in my op	e, date and place inion, death occu	e, and due to the caurred at the time, d	ause(s) and m ate and place,	anner as sta and due to	ted. the cause(s)	
	To the within To the	Me	29b. Signature and title of certifier	4/		29c. License	number		9d. Date signe			
	/		Alina 1	"Cerry		1	2 578	د)	le ()	104	r	
	6		30. Name and address of person who	completed cause of death (Item	23а) (Туре,	Print)	7 . V		le ()	4 '		
			Alan Kimme	8 MD 656		orth Cha	rules S	t 1Sal	X M	d2i	20K	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signat	are	20. 1.1						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2004 06 04 12:30 PM ennie McOsker Isola 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Riverview Care Center Baltimore Essex If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, June 1, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 1 ☐ M 2 🛛 F 93 Yrs. Marýland 217-07-8701 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Baltimore Essex Marvland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1 Eastern Blvd. 21221 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1XX Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) telephone operator phone company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JenniemIsola Paine Patrick McCusker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 63654 Buedingen Robert G. Parker/great nephew Steinweg 5 Germany 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Sacred Heart of Jesus Cem. 6/9/04 Dundalk, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc 21. Signature of Funeral Service Licensee 6500 York Rd. 21212 Baltimore, MD and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arterioscleratic pronary Uncolor Diene 42001. Due to (or as a consequence of) Due to (or as a consequence of):

Physician /Medical Examiner

ettending physician and for use as the buriel-transit

certificate has been signe lirector, page 2 should be

funeral director,

filled in by

efter death.

Director: Aft
d in by the fur

within 24 hours e To the Funerei I completely filled

ò

Attending Physicien: The law requires that the deeth certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

Completed by

Be

Certification: To

Medical

Part II

Physician

Examiner

Funeral

Director

filed within 72 hours after death with the Maryland

altimore, Maryland 21215-0020

iit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla intrnent of Health and Mental Hygiene. Trant: If them 27 is marked other then 'naturel', or Items 23e or 28e-f show injury or other traumatic event, it is Medical Examiner must be notified at injury or other traumatic event, it is Medical Examiner must be notified at

/Medical

10a. State

Funeral Director

þ

Completed

Be

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events

Due to (or as a consequence of):

resulting in death) Last

Other significent	conditions contributing t	o death but not	resulting in the un	derlying ceuse g	jiven in l	Part

23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ₩ hknown

deventa

24a. Was en eutopsy performed?

26. Place of Death (Check only one)

24b. Were eutopsy findings available prior to completion of cause of death?

os teopororis

1 ☐ Yes 2 40 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Day Yeer) 28b. Time of

28c. Injury at Work?

Other: 4 In wursing Home 5 | Residence 6 | Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 Homicide

5 Pending investigation 6 Could not be determined

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29a. Certifier (Check only one)

1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) and manner as steted. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie ruail our aryund 29c. License number 019667 29d. Date signed (Month, Day, Yeer) 06-05-2004

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Schwartz, MD

7310 Ritchie Hwy.

21061 Glen Burnie, MD

State Registrar

P

31. Date filed (Month, Day, Yea 8 JUN 0



			1- State of Maryland / Dep	artment of Health and Mertificate of Death		iene2 0 0 4	18091	
6	Physici		Decedent's Name (First, Middle, Last) DAVID BRIAN MUSGROVE		2. Date of Death Month JUNE	Day Year 1, 2004	3. Time of Death 1:30P. M	
	/Medio Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	00111	4c. County of Death		
			STULLTOWN & FELTON SCHOOL ROAD	SUDLERSVILLE		QUEEN ANN	E	
	Funeral Director		5. Social Security Number 215-66-1922 6. Sex X M 2 F 7. Age (In yrs. last birthda)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, APR 13,	rear) Co	hplace (State or Foreign untry) LTIMORE, MD	
	pur 🛊 😅		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or 1	ocation			10d Inside City Limits	
	farylan show	ō	MD ANNE ARUNDEL SEVERNA				10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	the M	Director	10e. Street and Number	10f. Zip Code	10	Og. Citizen of What Co		
	with Ba or	Ω	257 PUMPKIN COURT	21146		USA	unity ?	
	ns 20	era	11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Ame	rican Indian,	
21215-0036	ges 1 and 2 should ba filad within 72 hours after death with the Maryland it of Health and Mental Hygiene. If itam 27 is marked other than "natural", or Itams 23a or 28a-1 show or other traumatic avant, the Medical Examinan must be nutified at	by Funerai	Armed Forces? 1 □ Never Married 2 ▼ Married 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puèrto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, White Specify: Wh	e, etc.	
9-0	2 hou	Completed	15. Decedent's Education 16a. Dec	edent's Usual Occupation	1	16b. Kind of Business/	Industry	
215	thin 7 e. en "n	pie	life	e kind of work done during most of worki DO NOT use retired)	ng			
	ad wi	Con		'OREMAN		ELECTRIC	COMPANY	
Maryland	2 should ba filad withir and Mental Hygiene. Is markad othar than aumatic avant, Ine M	Be	17. Father's Name (First, Middle, Last) WILLIAM H. MUSGROVE	18. Mother's Name				
Ž	should ind Men s marka umatic	J.		ing Address (Street and Number or Rura	. LICHTE		Zin Code)	
≥	and 2 seath ar n 27 is					RK, MD 2114		
ē,	as 1 and 2 of Health itam 27 i		20a. Method of Disposition 20b. Place of Disposition	osition (Name of	ate 2	20c. Location - City or		
Ë	Pages nent of fi int: If its		I bullar 2 (Acternation 3 Removal from State	KE CREMATION JUNE	004 s	TEVENSVILI	E, MD	
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signa Are of Funeral Service Linensee MO1220		SECOND A		EN BURNIE,	
r			23a. P. nt. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate Interval Between		
100	Physician		Immediate Cause (Final disease or condition	true Lat Vous	Jof 4	est	Onset and Death	
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	3.	0 .			
Н	TAGE TO SERVICE TO SER	-	Sequentially list conditions, if any leading to immediate b. Que to (or as a consequence of):					
	urad I Insit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
ς,	sician and burial-transit	Examiner	resulting in death) Last C. Due to (or as a consequence of):					
8760,	ficate be ex physician a s the burial	dicai	d					
9	ntifica ng ph as th	Jed	IF FEMALE:			- г П		
Вох	leath certific attending p I for use as	an/	23b Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy		23d. Date of deli	*	
0.	the at	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5	Other (specify)		Month	Day Year	
<u>α</u>	res that the d igned by the ba detached		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?	
Records,	-= 0 0	ed by			1 🗆 Yes	s 2MNo 3□Pro	obably 4 Unknown	
900	e law requ has been je 2 shoul	Completed			24a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of	
Ä		E O			perform	ed? death?	2 No	
Vital	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	26. Place of Death	(Check only one	,)		
of \	ys dilb	은	1 X Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		ne 5 🗆 Residen		ity) SCENE	
	ding Ph h. After th funeral	ion	27. Manner of Death 1 □ Natural 5 □ Pending 28a. Date of Injury 28b. Time Injury Injury 28b. Time Injury 28	Work?	28d. Describe hov	w injury occurred	Laic	
Division	tan leat lor: the	icat	2 Accident investigation 2 Value of Could not be determined to the determined to th		af Location fre	eet and Number or Ru	m/ Pouto Number	
Θį	after Dira	Certification;	4 Homicide determined building, etc. (Specify)	del S	City or Town	State S La	RA	
	To the Hospital or Attant within 24 hours after deatl To tha Funaral Diractor: completely filled in by the		29a. Certifier (Cluck only 2	th occurred at the time, date and place, a	and due to the cau			
	the H nin 24 tha F nplete	Medical	and manner stated.			Mersville	to the chise(s)	
	Vith Con	~	29b. Signature and title of centiller	29c. License number	290	d. Date signed (Month	, Day, Year)	
,	$\overline{\Omega}$		Corye	O.C.M.E.	JU	NE 2,2004		
	10		30. Name and address of person who completed cause of death (Item 23a) (Type J.	111 Penn Street, B	altimore	, Maryland	21201	
	Sta Registr	37	31. Date tiled (Month, Pay, Year) 32. Registrar's Signature	boals				

			For State Registrer	State of	Maryland		artment of H rtificate of L		nd Mental		ne . No 2001	18092
	Physici		1. Decedent's Name (First, Middle,	Last) Ol Mednic	k				2. Date of Month		ρ ^{ay} 200 ^{¥ea}	3. Time of Death 7:50p M
>	/Medic Examin		4a. Facility Name (If not institution, Edenwald	give street and numb	er)		4b. City, Town, or TOW	Location of D			4c. County of De	
	Funeral Director		057-16-3149	. Sex 7. 1X M 2 ☐ F	Age (In yrs. la 82	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Month	Birth 2 Day, 1	921 N	Birthplace (State or Foreign Country) EW York
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Lo	cation	<u></u>				10d. Inside City Limits
	the Marylar 28a-f show	tor	Maryland Balt	imore			Towson					1 □ Yes 2 No
	or 28s	Director	10e. Street and Number			-	10f. Zip Code			10g	. Citizen of What	Country?
	s 23a		800 Southerly	Road Apt		12.3		286	2 (Canada Van	- No	USA	nerican Indian.
920	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-f show he Medical Exercites contined at	by Funerai	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Force	∍s? □NoWWII	.	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	Puerto Rican, etc)	Black, Wi	
2-0	72 ho	eted	15. Decedent's (Specify only highest			(Give	ient's Usual Occupa	lurina most o	f working	16	b. Kind of Busines	ss/Industry
21215-0036	be filed within tal Hygiene. Id other then event, It's Me	Completed	Elementary/Secondary (0-12)	College (1-4 5+	or 5+)	life. I	DO NOT use retired emist)			Organic	Chemistry
Maryland	ild be filed fental Hygirkad othar	To Be (17. Father's Name (First, Middle, La Harry Medni	•					s Name (First, Mi Esther M		· ·	
lary	s 1 and 2 should be f Health and Mental itam 27 is markad othar traumatic ev		19a. Informant's Name/Relationshi				ng Address (Street a	and Number o	or Rural Route N	umber, C	ity or Town, State	
	is 1 and 3 Health itam 27 other tr		Dorrie A. Medni 20a. Method of Disposition	ck/wlie	20b. Pla		Southerly sition (Name of	Road	Apt. 180		OWSON, M	
nor	Pages nent of H int: If its iry or of		1 Burial 2 XCremation 3		ate ce	metery, crer	natory or other place			20	Baltimo	
Baltimore,	permit. Pages Department of Important: If i any Injury or once.		1. Signature of F. McDonald Metro Crematory, Inc. 6/9 Dawn F. McDonald Metro Crematory, Inc. 6/9 22 Name and Address of Facility Cremation Society 299 Frederick Roa						ty of Ma	ryla	and, Inc.	
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that cau nly one cause on eac	sed the death.							Approximate Interval Between
	Pnysician :	8 0	Immediate Cause (Final disease or condition resulting in death)	a	U	0	5ep 51	5				Onset and Death
	/Medical Examiner		resulting in dealin)	Due to (or	as a conseque	ence of):	1	8				
	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or	as a consequ	ence of):						
Į.	xecuter and Il-transi	Examin	that initiated events resulting in death) Last	c	as a conseque	ence of):						-
8760,	cate be executed physician and the burial-transit	dicai E		d	`							
O. Box 6	ne death certifi the attending shed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		n 2 ☐ Fetal a at at time of dea	death 3	Ectopic pregnancy Other (specify)			_	23d. Date of d Month	delivery Day Year
0_	w requires that the been signed by should be detact	by	Part II. Other significant condition	s contributing to deat	th but not resul	lting in the u	nderlying cause give	en in Part I.		Did tobac	./	to the cause of death? Probably 4 □Unknown
Vital Records,		Completed							—	Mas an autopsy performed as 2	d? death?	autopsy findings available o completion of cause of es 2 \(\text{No} \)
Vita	Physician: This certificatal director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inp	entions 2 -	R/Outpatien	t 3 DOA Othe		f Death (Check of		e 6 ⊡Other (Sp	
n of	ing Phys After this uneral di	-	27. Mann of Death	28a. Date of (Month,	100	28b. Time of Injury	28c, Injury Work	at ?	28d. Desc		injury occurred	эвспу)
Division	al or Attending P safter death. I Diractor: After I d in by the funera	Certification:	1 A atural 2 Accident 3 Suicide 4 Homicide 5 Pending investiga 6 Could nc determin	t be 28e. Place of	Injury - At hon , etc. (Specify)	ne, farm, str	M 1 □ 1	∕es 2⊡No	28f. Locati	on (Stree Town, S	it and Number or i State)	Rural Route Number,
	Hospita 4 hours Funara fely fille	edicai C	29a. Certifier (Check only one)	Physician: To the be kaminer: On the bas and manne	is of examinati	vledge, death on and/or in	n occurred at the time vestigation, in my op	e, date and pointion, death	place, and due to occurred at the ti	the caus	e(s) and manner and place, and di	as stated. ue to the cause(s)
	To tha within 2 To the complet	Me	29b. Signature and title of certifier		,		29c. License				Date signed (Moi	nth, Day, Year)
	/		1/1/	1 1 m	In hy	n'un		29	769		4/5	104
	5		30. Name and addr ss of p Tson w	D. Also	vem	e an	5 16	, a. k	6/lin	RI	Brite	hr 2/228
	Sta Registi		31. Date filed (Month, Day, Year)		istrar's Signati	d'	Sparks		769 colling			

18093 State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 6:00 AM BARBARA MAE MCGREGOR-MURPHY JUNE 2004 6, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 509 GWYNNVALE ROAD PIKESVILLE BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 □ M 2 🕅 F Yrs. Director 63 242-62-2435 10-3-1940 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic avant, the Medical Evantiner must be notified at MD BALTIMORE PIKESVILLE Director WXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 509 GWYNNVALE ROAD 21208 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If itam 27 is marked other than "natural;, or ital 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼☐ No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) ARD MANAGER BCPS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALLIE HERRING ELMER BOYKIN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLIS MURPHY/HUSBAND 509 GWYNNVALE ROAD BALTIMORE, MARYLAND 21208 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages to Department of Himportant: If its any injury or ot once. 1 ■ Burial 2 Cremation 3 Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) KING MEMORIAL PARK 6/12/2004 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MARYLAND 21217 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** van dissure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, nding physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon for Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the a 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? λq Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 Yes 2 No 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Avatural 5 Pending within 24 hours after death. To the Funeral Director; A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Momicide 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) walls Andlw feite NO 212.07 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 8 2004

ORIGINAL

			1 - For Amend Items 23c	Pull 23 per lar	632,067017641	He Health and	Mental Hyg	iene	10001
			State Registrar 1. Decedent's Name (First, Middle, La		Certificate	of Death	2. Date of Deat		3. Time of Death
	Physici /Medio		Elizahoth	MUNG	dell		Month	Day Year	1-30.
4	Examir		4a. Facility Name (If not institution, given	re street and number)	4b. City, 1	own, or Location of Dea	th	4c. County of De	ath
	Funeral		BonSecours Ho 5. Social Security Number 6. 9	7. Age (In yrs.				9. B	rthplace (State or Foreign
	Director		219-10-07/0	1□M 2\1 F 79	Yrs. Months	Days Hours Min	Month, Day, 12/03/1		ryland
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Location				10d. Inside City Limits
	e Man Ba-feh Milled	ctor	Maryland		Baltimore				1★ Yes 2 No
	with th	Funeral Director	10e. Street and Number	1.0	10f. Zip		10	0g. Citizen of What C	country?
	death	nera	2 North Smallwo	12. Was Decedent Ever in U		1223 ent of Hispanic Origin? (S fy Cuban, Mexican, Puer	Specify Yes or No-	U.S.A.	
36	s after , or the	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2		to rican, etc.)	Black, Wh	ite, etc. lack
21215-0036	72 hours after death with the Maryland neturel', or items 23e or 28a-f ehow deal Examiner rust be notified at	tedt	15. Decedent's E	ducation	16a. Decedent's Usual		adain a	16b. Kind of Busines	
121	within 7 ene. then "r	Completed	(Specify only highest gr	College (1-4or 5+)	life. DO NOT use	k done during most of wa e retired) Processor	rking	Hospital	
	filled Hygi otther	a u	12 17. Father's Name (First, Middle, Last)	Decrire		me (First, Middle, M	Hospital Maiden Sumame)	
ylan	should be ind Mental s marked o umatic eve	To B	John Logan			Goldie	Johnson		
Maryland	d 2 sho		19a. Informant's Name/Relationship (Maxine Lyons / Ne	**		(Street and Number or R		-	
	s 1 and if Health item 27 other tr	15	20a. Method of Disposition	20b. F	Place of Disposition (Name emetery, crematory or other	Heights Ave		Ore, Mary.	
Baltimore,	Pages ment of I ent: If its ury or o		1 ☐Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Speci	THemoval from State	utus Mem. P	04/	17/2004 B	altimore,	Maryland
Balt	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Lic	**		Address of Facility The			
		2 0	23a. Part1. Enter the disease, or com	aplications that caused the deet		rk Hgts. Ave			Approximate
	Physician	e 1	shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	Doath				Interval Between Onset and Death
	/Medical Examiner	Ŀ	resulting in death)	Due to (or as a consen		dual Ha	- 0 -	and the La	17 hours
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. MASSIVE	neuce ot):	ebral tte	Morring	7	12/10015.
	ate be executed hysician and the burial-transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	COUMAN	N Toxici	1	A. CHE	XAMILYER	48 hours
8760,	be exessician a	lcal Ex	resulting in death, cast	Due to (or as a conseq	uence of);	The state of the s	ROVED BY MEDICALE		
Ö	tificate ng phys as the	ledic		_ d.		CERTIFICATION PRO			
Вох	eath certifica attending ph for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna	I death 3 Ectopic pre	gnancy		23d. Date of de Month	livery Day Year
P.O. I	at the de by the a tached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of d 9☐ Unknown	eath 5 Other (spe	cify)		17131111	Suy (Ga)
	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	by Pł	Part II. Other significant conditions	contributing to death but not res	ulting in the underlying ca	use given in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
ord	w requir been si should l	eted	Chronic A-	trial 1-100	MOST Alli		1 🗌 Yes	s 2)X No 3□P	robably 4 Unknown
Vital Records,	The law cate has b page 2 s	Completed	Counadin Therapy				24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
ital	sicien: Th certificate irector, pag	Be Cc	25. Was case referred to medical			26. Place of Dea	1 ☐ Yes 2, ath (Check only one	No 1∐Yes	3 2 No
of V	Physic this ce	P.	examiner? 1 A Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatient 3 DOA			nce 6 Other (Spe	cify)
lon	ding After fune	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)	28b. Time of 28 Injury M	c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	v injury occurred	
Division	I or Attendi after death. Director: A I in by the fu	tifica	3 Suicide 6 Could not be determined		ome, farm, street, factory,	office	28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
۵	pitel o		29a. Certifier To Certifying Pl	nysicien: To the best of my kno	wledge death occurred a	the time data and place			
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medical Exer	miner: On the basis of examina and manner stated.	tion and/or investigation, i	n my opinion, death occu	rred at the time, da	use(s) and manner as te and place, and due	s stated. To the cause(s)
	withii To the comp	Σ	29b. Signature and title of certifier	Ω_{0}	29c.	License number	29	d. Date signed (Mon	n, Day, Year)
	1		HIJEAT S	completed cause of death (Item	1 23a) (Type, Print)	27103	> '	t/12/0	14
	6		H. Nant Remoke	S, Bay Saco	os fast	11,2000	wast &	Altemor	estreet.
	Sta Registr	-	31. Date filed (Month, Day, Year) APR 1 5 2004	32. Registrar's Signa	G Son V				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 1 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 7:19 AM **Physician** JUNE Dianne Morris Nola /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner Baltimore 3alt7more If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Months ſ M 2 € F 220-52-5269 Director June 20, 1942 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Experiment and be notified at 1 ☐ Yes 2 No Maryland Harford Edgewood Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21040 USA 1394 Harford Square Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2½ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2√2 No Specify White Specify: ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) <u>Homemaker</u> Own Home 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Audrey Atwood Whitney Tull Kenneth Murray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2. Department of Health ar Important: If item 27 is any injury or other trat. 1145 Chipper Drive, Edgewood, Maryland 21014 Linda D. Dowell, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Towson, Maryland Hilltop Service Corp. 6/8/2004 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility MCCOMAS Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the attending physician and hed for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed

The law requires that the death certificate be executed Division of Vital Records, peen certificate has Physician: To the Funeral Director: After the completely filled in by the funeral death.

Be

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Certification:

24a. Was an autopsy perform Yes 2 1 ☐ Yes 26. Place of Death (Check only one) 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manger of Death 1 Natural 2 Accident 5 Pending

3 Suicide

29a. Certifier

4 Homicide

1 Inpatient investigation

2 ER/Outpatient 3 DOA

2 🗌 No 1 🗌 Yes

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title at certifier

Res ASKW13869

29d. Date signed (Month, Day, Year)

completed chiese of death (Item 23a) (Type, Print)

Hospital:

Sinai Hospital of Battimore, 2401 W. Belvedere Ave, Battimore Mo 32. Registrar's Signature

State Registrar

31. Date filed (Month, Day, Year)



DHMH 17 Rev 1/2001

within 24 hours a To the Funeral L

	_1	For State Registrar	State of Maryland		artment of Hotelin of L		Mental Hygie Reg	- 2011	4 80 G
Physicia /Medic Examin	an al	Decedent's Name (First, Midd OTI S a. Facility Name (If not institution	MCCULLERS		4b. City, Town, or		JUNE	Day Year 2 00 4c. County of Dea	4:55 P
Funeral Director		HARBOR S. Social Security Number 577–22–1402	HOSPITAL 6. Sex XIM 2 F 7. Age (In yrs. Ia:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y) 9-12-20	N/A ear) 9. Bin C N.	nthplace (State or Foreigountry) Carolina
lifed at	-	Jsual Residence of Decedent 10a. State 10b. Count Md. N/		Town or Lo					10d. Inside City Limi 1 1 Yes 2 □ N
permit Fages I and S. Should be little which it indus are bean with the maryand Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic avent, the Medical Exempter must be notified at once.	ral Di	10e. Street and Number 3016 Mallv 11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13.	10f. Zip Code 21230 Was Decedent of His f Yes, specify Cubar			. Citizen of What C USA 14. Race - Am Black, Whi	encan Indian,
natural', or the	Ď	1 Never Married 2 Ma 3 ₩ Widowed 4 Divorce 15. Decede (Specify only high	If Yes, Give 12 Year or Dates:	16a. Decec	i Yes X No sent's Usual Occupa kind of work done do	uring most of work	ing 16	Specify: B	
otal Hygiene.	œ	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle	o, Last)		gshoreme	en 18. Mother's Nam	e (First, Middle, Ma	iden Sumame)	orker
and 2 should ealth and Men m 27 is marks her traumatic	T	Clennie 19a. Informant's Name/Relation Rosalind Mo	ore (D)	217	Evans S	St.,Gle	al Route Number, C n Burnie	ity or Town, State,	060
Department of H Important: If Itel any injury or ott	0.000	4 □ Donation 5 □ Other (21. Signature of Funeral Service	3 □Removal from State (Specify) Licensee	Zio	sition (Name of natory or other place n Cem. Name and Addres	6-11	L-04 P	asadena	,Md.
nysician /Medical ixaminer	Examiner	23a. Part1. Enter the disease,	a. Due to (or as a conseque	Do not ent		g, such as cardiac			21217 Approximate Interval Batween Onset and Death
e attending physician and od for use as the burial-transit	ical Exa	resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	d		Dectopic pregnancy			23d. Date of de	
signed by the d be detached	۵	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant condi	4☐ Pregnant at time of dea 9☐ Unknown tions contributing to death but not result	ith 5	Other (specify)	n in Part I.	23e. Did tobac		Day Year o the cause of death? robably 4 Unkno
ate has page 2	e Completed	25. Was case referred to medic	ial /			26. Place of Deat	24a. Was an autopsy performed 1 Yes 2 1	prior to death?	utopsy findings availa completion of cause 2 2 40
this aldii	ToB	examiner? 1 Yes 2 0 27. Manner of Death 1 Natural 5 Pend 2 Accident inves 3 Suicide 6 Coul	Hospital: 1 npatient 2 Eligible 1 ling tigation d not be 2 line 2	R/Outpatien	28c. Injury Work M 1 Y	4 Nursing Ho at ? /es 2 No	me 5 ☐ Residenc 28d. Describe how	injury occurred	
4 hours atte	edical Certifi	4 Homicide deter	28e. Place of Injury · At hombuilding, etc. (Specify) ring Physician: To the best of my knowlal Examiner: On the basis of examination and manner stated.	edge, death	a occurred at the tim	e, date and place,	28f. Location (Stree City or Town, S and due to the caus red at the time, date	State) e(s) and manner a	s stated.
within 2 To the complete	Me		m who completed cause of death (Item 2	. () -	Print)	16773		Date signed (Monitorial Line)	2004
Sta			CHUNKHUN 311	00 S	south HA	MOVER S	ST BALT	IMORE N	10 21225

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Registrar

JUN 0 8 2004

		•	For State Registrar	State o	f Marylar	id / Depa <i>Cei</i>	artment of H	lealth a Death	and Mer		giene Rag. No.	2004	18098
			Decedent's Name (First, Middle, L.	ast)					2.	Date of De	ath		3. Time of Death
	Physici: /Medic		Gladys Melvon	na Phil	llips					Month May	Day 3.1	Year 2 00	4 6:15 A ^M
	Examin		4a. Facility Name (If not institution, g.				4b. City, Town, or	Location o			4c. (County of Deat	
			Saint Agnes Heal				Baltin					ı/a	
	Funeral		5. Social Security Number 6. 217–34–7723	Sex 1 ☐ M 2 🖫 TF	7. Age (In yrs. 66	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birt (Month, Da	y, Year)	Co	hplace (State or Foreign untry)
	Director		Usual Residence of Decedent	21		113.			บน	ly 23	, 19:	3/ Mar	yland
	ow ow		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
	Man a-f eh	tor	Maryland Howard		El	kridge							1 ☐ Yes 2 ☐ No
	th the	Director	10e. Street and Number				10f. Zip Code				-	zen of What Co	•
	23a	al	7242 Montgomery F	Road			21075					ed Stat	
336	perrit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f ehow any injury or other traumatic event, Ite Maries Examinating an ange.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Dece Armed Fo 1 Tes If Yes, Giv Year or D	2 XNo ve		Was Decedent of H f Yes, specify Cuba I □ Yes 2X No	ispanic Orig an, Mexican Specify:	gin? (Specify , Puerto Ric	y Yes or No an, etc.)		4. Race - Ame Black, White Specify: Wh	e, etc.
Maryland 21215-0036	2 hou	Completed	15. Decedent's (Specify only highest g	Education			lent's Usual Occup		of working		16b. Kin	nd of Business/	Industry
215	thin 7	nple	Elementary/Secondary (0-12)	College (1	1-4or 5+)	life. I	DO NOT use retired	1)				D 1	
7	led wi lygien her th		12	0		Custor	mer Servi		preser			Bank	<u> </u>
and	tal H	Be	17. Father's Name (First, Middle, Las Charles George Da						Viole				
Ĕ	hould d Mei mark matic	ဥ	19a. Informant's Name/Relationship			19b. Mailir	g Address (Street						(ip Code)
Za	nd 2 s Ith an 27 is		Lisa Schultheis		ter		S. Cente				_		04054
ē,	s 1 ar f Hea item other		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of natory or other place		Date			cation - City or	i in
E O	Pages ent of nt: If I		1 ☐ Burial 2 【XCremation 3 4 ☐ Donation 5 ☐ Other (Spec	□Removal from cify)	State	-			6/1/2	2004	Balt	imore.	Maryland
Baltimore,	perrat. Departmimperta Imperta any inju		21. Signature of Funeral Service Lic	Zink)	22	. Name and Addre	ss of Facility	y Hubba	ard Fu	inera	l Home,	Inc.
	10210		23a. Part1. Enter the disease, or co shock, or heart failure. List on	molications that o	caused the deal	h. Do not ent	er the mode of dyin	ens A	venue, cardiac or re	Balt espiratory ar	rest.	e, Mary	rland 21229 Approximate
			shock, or heart failure. List on					,		,,			Onset and Death
	Physician /Medical		disease or condition resulting in death)	_ d	tastati (or as a consec		Cancer						Seven months
	Examiner				liation		nitia						Three month
Ę		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		(or as a consec		ALL CLS	-					
\mathcal{V}	cuted	Examiner	Cause (Disease or injury that initiated events	c									
6	ficate be executed physician and s the burial-transit	EX	resulting in death) Last	Due to	(or as a conseq	uence of):							
8760	cate b	dicai	•	d			·····						
9	ding p	/Me	IF FEMALE:	23c. If ves. out	tcome of pregna	ancv					2	3d. Date of deli	NAD!
Вох	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live b	ointh 2 Feta	Ideath 3	Ectopic pregnancy Other (specify)				2	Month Month	Day Year
o.	the d y the	ysi	1 ☐ Yes 2 XNo 9 ☐ Unknown	9□ Unkn									
<u>α</u>	The law requires that the tite has been signed by the bage 2 should be detache	by Pi	Part II. Other significant conditions	contributing to de	eath but not res	ulting in the u	nderlying cause giv	en in Part I.	ĺ	23e. Did to	obacco us	se contribute to	the cause of death?
rds	w require been sig should b	ed b								1 X Y	∕es 2□	No 3∏Pro	obably 4 Unknown
Records,	aw requisite been	Completed								24a. Was autop		24b. Were au	topsy findings available completion of cause of
Ä	The law ate has page 2:	mo								perfo	rmed? 2 X No	death? 1 ☐ Yes	2 X No
Vital	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?						of Death (C				
of <	S 0	L P	1 ☐ Yes 2 X No			ER/Outpatien		4 🗀 1901				□Other (Spec	cify)
	Attending P r death. sctor: After t by the funera	Certification;	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigat		of Injury th, Day Year)	28b. Time of Injury	28c. Injun Work	yat k? Yes 2 □ N		. Describe h	now injury	occurred	
Division	Attendir death.	ifica	3 Suicide 6 Could not determine	286. Place	of Injury - At h	ome, farm, str	eet, factory, office		28f.	Location (S City or Tox		Number or Ru	ral Route Number,
Ö	s after s after si Direct	Cert	4 [] Nothicide	Dulius	arg, etc. (Specia	y/				ony or ron	in, State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai (aminer: On the b			occurred at the ting restigation, in my o						
	To the within 2 To the comple	Me	29b. Signature and title of certifier				29c. Licens				29d. Date	signed (Month	, Day, Year)
)			BAHRU	ND			P11	693			June	8, 200)4
	10		30. Name and address of person who Dr. Bahru, Saint					Avenue	a. BA1	timor	e, MI	D 21229	
	Sta	te	31 Date filed (Month, Day, Year)	32. R	Requetrar's Signa	ature			_,		_,		
	Registi		JUN 0 8	2004	And the fact that	St p	forther						

State of Maryland / Department of Health and Mental Hygiene State Registra MEND ITEM #17 PER FH G832 6 22/16/16/16/16 of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 04 2004 June 5:40a. M Patterson Elizabeth /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore North Oak Residential Center Pikesville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5220-36-6929 220-36-6929 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 ☐ M 2 🔽 F 93 Director ٧A Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Pikesville Baltimore MD Direct 10g. Citizen of What Country? 10e. Street and Number 23a or U.S.A. 21208 725 Mount Wilson Lane Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Ď **X**Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) other than Social Worker State of Maryland 5yrs 12th grade Pages 1 and 2 should be filed v trant of Health and Mental Hygie trant: If item 27 le marked other t ijury or other treumatic event, ID. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ARTHUR A. GALVIN Janie Toles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 19a. Informant's Name/Relationship (Type, Print) Beverly Cooper-God-Daughter 4100 North Charles Street, Unit 912 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Arbutus Memorial Park 6/11/04 Arbutus, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave 21. Signature of Funeral Service Licente Baltimore Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Malignancy Unknown marthi ntrachdon, no **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events attending physicien and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant. 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Atheroscherohe Varcolas 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Injury 5 Pending 1 Yes investigation 2 Accident efter death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide o the Hospitel within 24 hours To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 4 - 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MO 21202 DOEL MESHULAM 301 ST PAUL #605 0 -32. Registrar's Signature 31. Date filed (Month, Day, Year) State JIN 0 8 2004 Registrar

			For State	State of Maryla		artment of H			/ / / /	18100	
			Registrar 1. Decedent's Name (First, Middle, La:	st)		timodio oi L	704117	2. Date of Death		3. Time of Death	
	Physici		Adell	Paris	<			Month 5	Day Year 30 2004	10:00 p ^M	
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of Death	10.00 p	
			1318 N. Mount	Street		Balto			N/A		
	Funeral		Social Security Number 6. S 1	ex 7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign	
	Director		213-36-4545 Usual Residence of Decedent	69	Yrs.			3-29-35	5	S.C.	
	land ow		10a. State 10b. County	10c.	City, Town or Lo	cation				0d. Inside City Limits	
	Mary Indi	to	Md. N	Δ	Baltim	ore				1 X Yes 2 ☐ No	
	r 28s	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?	
	th wit	Funeral Director	1318 N. Mount St	reet		21217			USA		
	ems ems	Iner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,		
36	be filed within 72 hours after death with the Maryland ital Hyglene. ad other than "natural", or items 23a or 28a-f ehow od other than "natural", or items 23a or 28a-f ehow event, The Madical Examinar must be notified at	by F.	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2X No If Yes, Give		1 ☐ Yes 2 ☐XNo	Specify:			ack	
8	hour fural	ed b	15. Decedent's Ed	Year or Dates:	16a, Dece	ient's Usual Occupa	ation	10	6b. Kind of Business/In		
5	n "na	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed)	(Give	kind of work done a DO NOT use retired,	luring most of work	ng	ob. Tallo of Edomogalii	Guotiy	
212	d with giene.	E	8th grade	College (1-4or 5+)	Ca	re Giver		F	oster Care	Parent	
B	e filed al Hygid other vent, I	Bec	17. Father's Name (First, Middle, Last,				18. Mother's Name	(First, Middle, M	aiden Sumame)		
Maryland 21215-0036	2 should be f and Mental H ie marked of raumatic ever	ည	Leroy	Paris	s, Sr.		Sarah	Lee	e Haynes		
Nar	2 should and raum		19a. Informant's Name/Relationship (-			City or Town, State, Zip	_ ′	
e,	1 and Health In 27 thar t	3	Robert Jefferson 20a. Method of Disposition			8 N. Moun			Md. 2121 Oc. Location - City or To		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any fulury or other traumatic a gnce.		1 Burial 2 Cremation 3	Tuellional light State		sition (Name of natory or other place					
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Ba	Dep sany	21. Signature of Funeral Service License 22. Name and Address of Facility 1							Balto, Md	21202	
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9		edic		0.							
Box	death certific e attending p id for use as	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ F		Ectopic pregnancy			23d. Date of delive	•	
	0 0 0	sicis	in the past 12 months? 1 🗆 Yes 2 🔊 No	4☐ Pregnant at time of		Other (specify)			Month	Day Year	
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Records,	e la has	Completed						24a. Was an autopsy performe	prior to co	psy findings available npletion of cause of	
Vital	iclan: Th certificate rector, pag	e C	25. Was case referred to medical				26. Place of Death		No 1 ☐ Yes	2 No	
>		To B	examiner? 1 □ Yes 2⊈ No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatien	t 3 DOA Othe			ce 6 □Other (Specifi	()	
J Of	ding Phye		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		at :	28d. Describe how		,	
Ö	Attending r death. actor: After by the fune	atic	Natural 5 Pending investigation	n	,, ,		res 2 □No				
Division	i or Attendent efter death Diractor: Jin by the	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - A building stc. (Spe	t home, farm, str ecify)	eet, factory, office	:	28f. Location (Stre City or Town,	eet and Number or Rura State)	l Route Number,	
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	To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: After completely filled in by the funer	Me	290 Signature and title of certifier	1100	1-10	29c. License	number	290	d. Date signed (Month,	Day, Year)	
)	(Tomas	#	Allan	DOC	19419	I	UNE 3	2004	
	1/		30. Name and address of person who	completed cause of death (I	tem 23a) (Type,	Print)	_ D		_ \>	- 10 - 0	
	•		DIANA H. G	RIFFITAS	400 C	ATON H	VE, D	ANTIMOR	E LID	71227	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature 4	loan V	/				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Day **Physician** BORGHILD H. PRIOR 2004 JUNE 2:40a /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHARLESTOWN CARE CENTER CATONSVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 214-14-3714 1 ☐ M 200 F 95 Director 27,1908 MARYLAND NOV. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyghene. Important: if item 27 is marked other than "neturel", or items 23s or 28s-f show any injury or other traumatic event, Ita Madical Examiner must be notified at once. MD CATONSVILLE BALTIMORE 1 ☐ Yes 2X No Completed by Funeral Director 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 719 MAIDEN CHOICE LANE 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 Never Married 2 Married ☐Yes 2 XNo 1 ☐ Yes 2 🛛 No WHITE Specify: If Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DIRECTOR OF VOLUNTEERS HOSPITAL ADMINISTRATOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CARL W. PRIOR MARGA CHRISTENSEN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $5422~\rm OLD~FREDERICK~RD.~BALTO.,~MD.$ 19a. Informant's Name/Relationship (Type, Print) 21229 CARL CUMMINGS nephew 20b. Place of Disposition (Name of cemetery, crematory or other place)
LOUDON PARK CEM. 20a Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 06/08/2004 BALTIMORE, MD. 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HENRY W . JENKINS SONS Conso 21111 16924 YORK ROAD, MONKTON, MD. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Sep515 'Medical Due to (or as a consequence of): kaminer Sequentially list conditions, if any, leading to immediate cause. Enter of identifying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of) attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 Other (specify) the a 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ funeral director, page 2 should be 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 20 No this certificate 1 ☐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 32 No Certification: To 2 ER/Outpatient 3 DOA 6 ☐Other (Specify) Nursing Home 5 Residence 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Injury Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 4 - Homicide pelli To the Hospital 29a. Certifier 🛍 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier

State Registrar

JUN 0 8 2004

+ndi in

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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when

DHMH 17 Rev 1/2001

the Maryland

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

Box 68760

P.O.

Division of Vital Records.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2:45 PM 2004 June Margaret E. Protzman 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street end number) Baltimore Manor Care Ruxton Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Bay, Year) 14 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdev) Months Maryland 1□ M 2 F 213-10-7390 89 Yrs Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No MD Baltimore Ruxton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7001 Charles Street 21204 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Licensed Practical Nurse Nursing 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) James C. Barbour Rebecca D. Eaton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16115 Kanny Road; Laurel, MD 20707 William Protzman, Jr. / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Moreland Memorial Park 6/5/04 Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Puneral Service Licensee 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) · ACUTE STROKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? Cardionyo, 24a. Was an autopsy 1 Vee 200 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 4 Varursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

The lew requires that the death certificate be axecuted use es tha buriel-transit ettending physician end for use es tha buriel-trae Division of Vital Records, P.O. Box 68760 signed by the et d be detached for Aftar this cartificate

Physician/Medical Examiner Completed by

Physician

/Medical

Examiner

Director

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Director

Peges 1 and 2 should be filed within 72 hours efter death with the Marylend nant of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or thems 23a or 28a-f show

Saltimore, Maryland 21215-0020

Item 27 is marked other than "natural", or flems 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at

Depertment of important: If it any injury or o

Physician

/Medical

Examiner

To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this cartifica completely filled in by the funeral director, g To the I within 2 To the I

Medical Certification: To Be

4 \ Homicide

29a Certifier

State Registrar

31. Date filed (Month, Day, Year) JUN 0 B 2004

29b. Signature and title of certified

H. GHILADI. MD. 7600 32. Registrar's Signature

e Willenin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D-12849

29d. Date signed (Month, Day, Yeer)

LER Dr. TOWSON, MD 21204

Please Type or Print in Black Indelible Ink	Ensure All Copies Are Legit
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		_	State Registrar			Cei	tificate	e of L	Death		2. Date of De	Reg. No	fice, U	09	10	103
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I	Funeral		5. Social Security Number 214-18-9413	i.Sex 1 □ M 2 🛣 F	7. Age (In yrs. I 9	* * *	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Jan. 3	v. Year	12	9. Birth Cou	place (State ontry)	or Foreign
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Maryland	2 should and Men is marke eumatic		19a. Informant's Name/Relationshi				-				al Route Numbe	-				1
	1 and Health em 27 ther tr	Mr. Michael J. Alexander/Son 8342 Tally-Ho Road Lutherville, Maryland 21093														
по	Pages nent of int: If it		1 🔀 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State	_{emetery, crer} t Holy	natory or o	ther place		5/5/0)4				arylan	d
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89 x	certific nding p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come of pregna	ncy				Marie Control			23d Dat	e of deliv	erv	
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oţ	Attending Physician: r death. ector: After this certifica by the funeral director.	n: To	1 Yes 2 No 27. Manner of Death	28a. Date o	f Injury	28b. Time of		8c. Injury	at Nu		me 5 Resid 28d. Describe h				fy)	
ion	ending sath. or: Afte he fun	atlo	1 Natural 5 Pending 2 Accident investiga	tion	n, Day Year)	Injury	М	Work	Yes 2 🗆	No						
Division	or Att	Certification;	3 Suicide 6 Could no 4 Homicide determin	286. Place	of Injury - At ho ig, etc. <i>(Specify</i>	ome, farm, str /)	eet, factory	, office			28f. Location (S City or Tov			er or Run	al Route Num	ber,
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifier 12 Certifying	Physician: To the	best of my kno	wledge, death	occurred	at the tim	ne, date an	d place,	and due to the	cause(s)	and ma	nner as s	stated.	
	the Ho in 24 l the Fu pletely	ledical	one)	xaminer: On the ba and mann		tion and/or in				th occurr)
	To t To t	Σ	29b. Signature and title of certifier	Donol	Lun.	MO			number 059	872			- /	3 / O	Day, Year)	
7	0		30. Name and address of person w	ho completed cass	of death (Item	23a) (Type.	Print)						- 1	- 1	1	
	8		6701 N. Ci	rancs	5+.	Balt	mo	re,	MI	>	212	14				
	Sta Registr		31. Date filed (Month, Day, Year)		egistrar's Signa		bour	.,								
			A 2544 A O 2700			- 19	ما ما استا مرد	2	-							

State of Maryland / Department of Health and Mental Hygiene 2001

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_		-	- 1

				(Certificate	of	Death		R	eg. No.	0 4	10104
			1. Decedent's Name (First, Middle, Last)						2. Dete of Deet Month	h		3. Time of Death
	Physici		Elouise Perkins		Jun					, ^{Dey} 2004	Year	12:50P.
	/Medi Examir		4a Fecility Neme (If not institution, give street and number)				4b. City, Tov		cation of Death	4c. County	of Death	
a.d	Exami		Keswick Nursing Home			F	Balti	more	ے		$N/_{\Delta}$	
	Funeral		5. Social Security Number 6. Sex 7. Age (I	n yrs. lest birth	day) If Under 1		If Under 2	24 Hrs.	8. Date of Birth 9. Birth			lace (State or Foreign
	Director		216-28-0881 ^{1□M} ⅔ F	71 Yr	s. Months I	Hours	Min.	Nov.	Ov. 2, 1932 S. Caroli			
	D	١	Usuel Residence of Decedent									
	ylen how	125	700 - 1000	Oc. City, Town							1	0d. Inside City Limits
	Me	io	Maryland N/A	Balt	imore							*YYes 2□No
	filed within 72 hours efter deeth with the Merylend Hygiene. ther than "natural", or Nems 23s or 28e-f show ant, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number		10f. Zip C	ode			1	Og. Citizen of V	What Cour	ntry?
	h wii	al	3225 Ingleside Avenue		212	15	5		Ţ	JSA		
	eep EE	ner	11. Marital Status 12. Was Decedent Eve Armed Forces?	or in U,S.	13. Was Deceder If Yes, specify	t of F	lispenic Orig	gin? (Spe	city Yes or No-		e - Americ	
0	or he	3	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X		1 ☐ Yes 25		Specify:	, ruento	riioari, oto.)			
8	Pai',	δ	3 Widowed 4 Divorced Year or Dates:		10 165 23	2 140	Зреспу.			Specify	: BT	.ack
5	72 h	Be Compieted	15. Decedent's Education (Specify only highest grade completed)	//	ecedent's Usual (Give kind of work	done	durina most	of worki	na	16b. Kind of Bu		*
7	thin .	npi	Elementary/Secondary (0-12) College (1-4or 5+)	7	fe. DO NOT use	retire	d)		2	Social	Sec	urity
7	or th	ပ္ပ	12th grade		Clerk					dmini		tion
밀	a H d	Be	17. Father's Neme (First, Middle, Last)				18. Mother	r's Name	(First, Middle, N	Aaiden Surnam	10)	
S	should be and Mental marked o umatic eve	ို	Sylvester Jackson						rshall			
Maryland 21215-0020	2 sho end te me		19a. Informant's Name/Relationship (Type, Print)						l Route Number,	City or Town,	State, Zip	Code) 21215
	end a		Johnnetta Lomax/ Daughte		13 Beau		ort A	ve	Baltim	ore,	Mary	land
Baltimore,	- I = =		Zou. Monios of Dioposition		isposition (Name crematory or othe		сө)	6	/ 8 / 0 /	20c. Location -	-	
Ĕ	Pages nent of int: If Its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Druid	Ridge C	en	eter	У (0,01 E	ikesv	ille	, Marylan
三	permit. Depertriments any injustre.		21. Signature of Functal Service Licentee		22. Name and	Addre	ss of Facility	Cha	atman-H	Tarris	Fun	eral Home
œ	Depertment of the policy of th		Tan to		5240 Re							Md 21215
		\vdash	262. Part1. Egrer the disease or complications that caused the	e death. Do not	enter the mode of	of dyir	ng, such as o	cardiac o	r respiratory arre	est,		Approximate
a Circumstance	Physician		shock or heart faflure. List only one cause on each line.									Interval Between Onset and Death
£	/Medical		Immediate Cause (Final disease or condition resulting in death)	~ 06	chart	7 .	01		alisp A			10411)
	Examiner			e to (or as a co				vig	CK 261	3.4	-	7
		٦		5 to (01 23 2 co	isoquorioo orj.						1	J
	es that the death certificate be executed igned by the attending physician and be detached for use es the bunal-transit	edicai Examiner	Sequentially list conditions	e to (or es a co	nsequence of:							
o`	exection and rial-tr	X	if any, leading to immediate	,	,							
68760,	ysicia	cai	cause. Enter Underlying Ceuse (Disease or injury that initieted events Due	o to (or as a cor	nsequence of):							
89	g ph g ph	8	resulting in death) Last	(*)	,						i	
ŏ	n cert andin use	2	d								<u> </u>	
<u> </u>	death a atte	icia	Part II. Other significant conditions contributing to death but n	ot resulting in the	ne underlying cau	se div	en in Part I		23b. Did to	bacco use cor	ntribute to	the cause of death?
<u>Р</u> О	by the	Physician		-					1XY		3 ☐ Prot	
	ned!	by P	weren corect	nyo	porcy							
Records,	The lew requires thet the death ste hes been signed by the atter page 2 should be detached for a	ᅏ	Diabetes wellitu	, 0					24a. Was ar		24b. We	are autopsy findings
္ပ	w require	jet	Thouse meeting	·					perform	100 /	COI	ailable prior to mpletion of cause death?
æ	he lev s hes	Completed							0.190	· star		
	icete		25. Was case referred to medical				00 81	-1.0	11140			Yes 2□ No
Division of Vital	Physician: this certific	Be c	examiner?	0 □ 5 D/O +-	O DOA	Oth	1,000		(Check only one	-	- 10 11	
ō	Phys rei d	<u>د</u>	1 ☐ Yes 2 No 1 ☐ Inpatient 27. Menner of Death 28a. Date of Injury	2 ER/Outp	4.00	Injur			ne 5 Reside 28d. Describe ho			0
5	Attending or death. •ctor: After by the fune	ρ̈́	1 SNatural 5 ☐ Pending (Month, Day Yo	ear) Inju	ry M	Injur Wor	k? Yes 2 ⊡N	10		, ,		
S	deat deat ctor: y the	fica	3 Suicide 6 Could not be 28e. Place of Injury	- At home, farm	, street, factory, o	ffice	_	- 1	28f. Location (Str	eet and Numb	er or Rura	l Route Number,
<u>S</u>	after Dire	Certification:	4 Homicide building, etc. (5	Specify)	, , .				City or Town	State)		
	ours ours eral filled	2	29a. Certifier 1 Certifying Physician: To the best of m	v knowledge, d	eath occurred at	he tir	ne date and	l place, a	nd due to the ce	use(s) and ma	nner as st	ated
	To the Hospital or Attending Physician: The iew within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	edical	(Check only one) Z Medical Examiner: On the besis of example and manner stated									
	of the office of	Me	29b. Signature and title of contifier	0			e number			d. Date signed		· '
	⊢ s ⊢ ō	1	M thathe mas it al	in w	w F)_	520	25	[7	UNO	2:	700×
	17	, 1	30. Name and address of person who come at cause of deet	Warn 23a) (T.	rne Print)		.2			3 . ~	1.	
	1	`	30. Name and address of person who come as cause of deep		11 N.	a	har	les d	+ Bal	to u	ed a	200x 2020x
	C	10	31. Date filed (Month, Day, Year) 32. Registrer's		- 1 - ' '							
	Sta Registr		11IN 0 8 2001 Amer	~ A	lan	1	,					

			1 - For State Registrar	State of	of Marylar		artmen rtificat				•	giene Reg. No.	2001.	18	105
	Physici /Medic Examin	al	Decedent's Name (First, Mid-Bernice Bernice 4a. Facility Name (If not instituti	perion, give street and nu	•		4b. City,	Town, or	Location of	of Death		Day AY 3	3인, 2인인 County of Dea	4 5:3 th	
	Funeral Director		Saint Jose 5. Social Security Number UNK	6. Sex	7. Age (In yrs. 72		If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bir 07/04	† 793		timor thplace (State puntry) LO	
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. Coun MD Bal	timore		ty, Town or Lo									City Limits
	ath with the 23e or 28	rai Dire	10e. Street and Number 4325 Hamilt			10-11-	10f. Zip	212				U	.S.A.		
980	72 hours after death with the Maryland netural', or items 23e or 28e-f show oreal Examiner must be notified an	Completed by Funeral Director	11. Marital Status 1 □Never Married 2□ Ma 3 □ Widowed 4 □ Divorce	Armed F 1 ☐ Yes If Yes G	2 (⊒XNo ive	1	Was Deced If Yes, spec 1 Yes		ispanic Origin, Mexican Specify:		cify Yes or No Rican, etc.)		14. Race - Ame Black, Whit Specify: B		
21215-0036	d within 72 ha giene. Ir than "netu	ompleted		ent's Education lest grade completed, College () (1-4or 5+)	16a. Dece (Give life. Park	dent's Usua kind of wo DO NOT us Atte	rk done d se retired	during mosi)	t of workin	9		nd of Business York	·	Gov.
Maryland	should be filed and Mental Hygis markad other umatic avant, II	To Be C	17. Father's Name (First, Middle Mack Peaco							Saı	(First, Middle, rah Cı	rump			
	d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		19a. Informant's Name/Relation Sidney Peace 20a. Method of Disposition 1 □ Burial 2 □ Cremation	ock -Son		1	12 14	12nd	l Ave	. Ja		a, N	ew You	k 11	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or othar once.		4 ②Donation 5 □ Other 21. Signature of Euneral Service	(Specify)		22	2. Name an	d Addres	s of Facilit	y Aus	stin F	Roys	ashing ter Fu sh, DO	inera	1 Home
8760, 1	Physician /Medical Examiner superinged by sician and physician and physician and superinged by the physician superinged by the physician of th	dical Examiner	23a. Part1. Enter the disease, shock, or feart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. RES Due to b. SEP Due to c. PNE	caused the dealeach line. FIRATO (or as a consect SIS (or as a consect UMONIA (or as a consect Consec	Quence of):			g, such as	cardiac or	respiratory a	rrest,		Approxim Interval E Onset an	Between
O. Box 68	death certif e attending ed for use as	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♣No 9 □ Unknown	1 Live	utcome of pregn birth 2 Feta nant at time of conown	aldeath 3	□Ectopic pr □ Other (sp				2145	2	23d. Date of de Month	livery Day	Year
٦.	wrequires that the been signed by th should be detache	by	Part II. Other significant condi END STAGE RENA		death but not re	sulting in the u	inderlying c	ause give	en in Part I.		23e. Did t		se contribute to		of death?
Vital Records	The law ate has b page 2 sl	Completed									1 Yes	psy prmed?	24b. Were at prior to death?	completion o	s available f cause of
of	ding Phys	atlon: To Be	25. Was case referred to medie examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Peni 2 Accident inves	Hospital: 128a. Date		ER/Outpatier 28b. Time o Injury		8c. Injury	er: 4□Nu ⁄at	rsing Hom	(Check only only only only only only only only	dence 6	S □Other (Spe y occurred	cify)	
Division	ital or Attanous after death ral Diractor: led in by the	Certification:	4 Homicide	mined 286. Plac	e of Injury - At h ling, etc. <i>(Speci</i>	ify)					City or Tov	wn, State)			umber,
	To the Hospital or At within 24 hours after or To tha Funeral Diract completely filled in by	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier		be best of my kn basis of examination nner stated.	owledge, deat ation and/or in	vestigation	, in my o	ne, date and pinion, dear	d place, au th occurre	d at the time,	date and	and manner as place, and due e signed (Mont	to the cause	
)	o T with		30. Name and address of person	10 LW		,~-		D318	826			_	30-0	A	
	Sta Regist		RICHARD LIA 31. Date filed (Month Day. Yes	THICUM,		601 O	SLER	DR	LVE.	TOW	50N, I	MARY	LAND ;	21204	

			State of Maryland / Department of State of Maryland / Department		ntal Hygie	C004	18106
			1. Decedent's Name (First, Middle, Last)	2.	Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		PERRY JOSEPH PERRY		June c	2004	6:45 AM
	Examin			wn, or Location of Death		4c. County of Death	
			Cition and the cities of the c	Himore		N/A	
	Funeral Director		5. Social Security Number 570-02-5243 6. Sex 7. Age (In yrs. last birthday) If Under 1. Months 5. Months 6. Months	ays Hours Min.	Date of Birth (Month, Day, Ye UG 25.	ear) 9. Birth Cou 1956 Cal	place (State or Foreign ntry) ifornia
	p ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If Item 27 is marked other than "naturel", or Items 23a or 28e-f show entry injury or other traumatic event, the Medical Exarting Final be rutilised at once.	ctor		e Valley			10d. Inside City Limits 1 ☐ Yes 2 No
	or 28	Funeral Director	10e. Street and Number 10f. Zip Co		10g.	Citizen of What Cou	ntry?
	ath w	ra	15486 Kiamichi Road #2	92307		USA	
	er de	nne	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent If Yes, specify	t of Hispanic Origin? (Specif Cuban, Mexican, Puerto Ric	y Yes or No- can, etc.)	14 Race - Amen Black, White,	
36	rs aff	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ሺ No If Yes, Give 1 □ Yes 2 ሺ 3 □ Widowed 4 ሺ Divorced Year or Dates:	No Specify:		Specify: Wh	ite
215-0036	houn	edt	15. Decedent's Education 16a. Decedent's Usual C	Occupation	166	o. Kind of Business/In	ndustry
15	In 72	plet	(Specify only highest grade completed) (Give kind of work of the DO NOT use	done during most of working			,
212	iene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Arbori	st		Tree Indu	strv
	a filed Il Hygi other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (F	First, Middle, Mai		
'lar	ould ba I Mental narked o	To E	Ward S. Perry, Sr.	Anita	L. Quatt	rociocche	
Maryland	short sma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (S	treet and Number or Rural F	Route Number, C	ity or Town, State, Zip	Code)
	and 2 salth n 27 i		Anita L. Quattrociocche/mother 15486 Kiam	ichi Road #2	Apple V	Malley, CA	92307
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name cemetery, crematory or other	r place)		c. Location - City or To	
Baltimore,	t. Partmen		4 Donation 5 Other (Specify) Metro Crematory			Baltimore,	MD
Bal	Depared Important Importan		21. Signature of Funeral Service License Mulc Dawn Functional 299 Free	on Society of derick Road	Marylar Baltimor	nd, Inc. ce. MD 212	28
П			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.	f dying, such as cardiac or re	espiratory arrest,	,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a Bacteria Per	itonitis			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
1		<u>~</u>	Sequentially list conditions frany, leading to immediate b. Due to (or as a consequence of):				
	utad I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury				
oʻ	exection and and rial-tra		that initiated events c. resulting in death) Last Due to (or as a consequence of):				
926	death certificate be executad e attending physician and od for use as the burial-transit	Ical	d.				
89)	leath certifica attending phi I for use as th	Physician/Med	IF FEMALE:				-
Box	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?			23d. Date of deliver	ery Day Year
0.	that the de nad by the a detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 5 ☐ Other (speci	fy)			,
α.	that that that and by detact	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	se given in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
Records,	aw requires that the as been signad by th 2 should be detache	d by			1 🗆 Yes	2XNo 3□Prot	oably 4 Unknown
00	w req	lete			24a. Was an	24b. Were auto	ppsy findings available
Re	nysician: The law nis certificate has t I director, page 2 s	Completed			autopsy performed	prior to co death?	mpletion of cause of
Vital	an: T	a	25. Was case referred to medical	26. Place of Death (C		No 1 Yes	2 110
<u>></u>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 No Hospital:	Other: 4 Nursing Home	5 Residence	e 6 ☐Other (Specif	(v)
J Of	<u>a</u> = <u>a</u>		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c (Month, Day Year)	Injury at 280 Work?	d. Describe how i	njury occurred	
Sio	Attending r death. sctor: After by the fune	catic	2 ☐ Accident investigation M	1 ☐ Yes 2 ☐ No			
Division	l or Att after de Direct	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, o building, etc. (Specify)	ffice 28f	Location (Stree City or Town, S	t and Number or Rura Tate)	al Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at 2 Medicel Examiner: On the basis of examination and/or investigation, in and manner stated.	the time, date and place, and my opinion, death occurred	d due to the caus at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. L	icense number	29d.	Date signed (Month,	Day, Year)
			Perica of Caise MD	217662	J	une 04	,2004
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			d 2120	
			31. Date (iled (Month, Day, Year) 38. Registrar's Signature	timore, Mu	ingland	d 2120	
	Sta Registi		JUN 0 8 2004				

			For State Registrar	State of Mary	-	artment of rtificate o			iene 004	18107		
	Physici		Decedent's Name (First, Middle, Las DENISE	L. PRICE			2. Date of Death Month Day Yeer AAA 3. Time of Dea					
	/Medic Examin		4a. Facility Name (If not institution, give									
	Funeral Director		5. Social Security Number 6. Sec. 219-70-0440		yls. last birthday) Yrs.	If Under 1 Year Months Day		s. 8. Date of Birth	Year) 9. Bird /58	hplece (State or Foreign untry) MD .		
	land	tor	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	ocation	<u> </u>			10d. Inside City Limits		
	a-f sh		MD. na		ВА	ALTIMOF	RE	1 Yes 2 ☐				
	vith the	Director	10e. Street and Number 10f. Zip Code				1	0g. Citizen of What Co	ountry?			
	leath v	Funerai	3606 WOODL	EA AVE. 12. Was Decedent Ever	in U.S. 13.	Was Decedent o	21214 f Hispanic Origin? (Specify Yes or No-	USA 14. Race - Ame	nican Indian.		
920	n 72 hours after death with the Maryland *natural', or Items 23a or 28a-f show calcal Exactifier nater by nutiling at	To Be Completed by Fun	1 Never Married 2 Marned 3 Widowed 4 Divorced	Armed Forces? 1		If Yes, specify Cu	uban, Mexican, Pue	rto Rican, etc.)	Black, Whit			
15-0	- 40		15. Decedent's Edi (Specify only highest grad		(Give	dent's Usual Occ kind of work don DO NOT use reti	ne during most of we	orking	16b. Kind of Business	Industry		
21215-0036	d within giene. or than		Elementary/Secondary (0-12)	College (1-4or 5+)		DMEMAKE			HOME			
Maryland	tal Hid oth		17. Father's Name (First, Middle, Last) JOSEPH PH	RICE			1	ame (First, Middle, I	Maiden Sumame) PRICE			
Man	2 sho and Is m		19a. Informant's Name/Relationship (7)	•		•			, City or Town, State, 2			
	s 1 and if Health item 27 other tr		20a. Method of Disposition	PRICE	Ob. Place of Dispo			VE BALTO	$0. \mathrm{MD}$, 21 20c. Location - City or	214 Town, State		
imo	m O		1 to Burial 2 ☐ Cremation 3 ☐ 1 d ☐ Donation 5 ☐ Other (Specify		•	ION		5/04	LANSDOWN	E,MD.		
Baltimore,	permit. Page Department Important: If any injury o		21. Signature of Funeral Service Licens	Step	22	TSTEP 1300	ress of Facility BROS. F EUTAW P	UNERAL H L. BALTO	HOME P.A.	217		
8			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final									
) 	Physician /Medical		disease or condition resulting in death)	a. 50 7915 Due to (or as a cor	nsequence of):		-					
*	Examiner	_	Sequentially list conditions b. Acquired Immunodeficiency Syndrome									
	nsit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury									
oʻ	cate be executed physician and the burial-transit	Exa	that initiated events c. resulting in death) Last Due to (or as a consequence of):									
68760,	cate by physici the bu	dical	(d								
.O. Box 6	death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ♀♥ Onknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown						23d. Date of delivery Month Day Y			
Q	requires that the een signed by th nould be detache	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				given in Part I.	23e. Did tob	23e. Did tobacco use contribute to the cause of death			
ords	w require been sig should b							1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown				
of Vital Records,	The law ate has b page 2 sl	Completed							24a. Was an autopsy performed? 1 Yes 2 No			
V.	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 ER/Outpatier	at 3 DOA	ther	ath (Check only on		.72.1		
	fter	Medical Certification: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28					ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			
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	0		30. Name and address of person who c	Prvelis 6	(Item 23a) (Type,	Print) OCH K	aven F	and Bo	1 Himon	1,2004 P. MDZIZ39		
£q.	Sta Registr	_	31. Date filed (Month, Day, Year)	32 Registrar's S	Signature	for 1	' /			, , , , , , , ,		

DHMH 17 Rev 1/2001

Denise Price

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4a. Facility Name (If not institution, give street and number) Greater Baltimore Medical Center Towson Funeral Director Funeral Director Funeral Director Towson Security Number 6. Sex 94			For State Registrar	State of Maryland		artment of I rtificate of		Mental Hy	/giene Reg. No	000	L 1810	
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Creater Balt/Incre Case Section Case								June 3	3, 20	04	5:55 P	
South Security Number South Security South Securit	Examir	ner				4b. City, Town,	or Location of Dea	ath	40	. County of De	ath	
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Immediate Cause (Final disease or condition redulting in death) Immediate Cause (Final disease) Immedi			23a. Part1. Enter the disease, or complishock, or heart failure. List only o	ications that caused the death.							Approximate	
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	Funeral		Social Security Number 6.		Age (In yrs. I	•	If Under 1 Yea Months Day	r If Under 24 H	n. (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
	Director		219-12-3464 Usual Residence of Decedent	201W	81	Yrs.			May 22,	1923 N	Maryland
	yland yland		10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	e Mar 3a-f sl	ctor	MD Anne An	cunde1		Mi	11ersvi1	.1e			1 ☐ Yes 2 No
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5	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-f show than "natural", or Items 23s or 28s-f show he Madical Examiner must be notified at	Completed by Funeral Director	15. Decedent's (Specify only highest g	Education rade completed)		16a, Deced (Give	dent's Usual Occi kind of work don DO NOT use retir	upation e during most of w ed)	vorking	16b. Kind of Busin	ess/Industry
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힏	be filed ital Hygie od other event, II	Be C	17. Father's Name (First, Middle, Las	st)				1	ame (First, Middle, M		
Maryland 21215-0036	should b ind Ments marked umatice	To	Unknown						a Glaser		
Mar	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship Mrs. Thelma Rola						Rural Route Number,		
	Health Health tem 27		20a. Method of Disposition	ind / wire			Dogwood sition (Name of natory or other pi		11ersville	MD 211 20c. Location - City	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.		21. Signature / Funeral Farrice Lic			22	. Name and Add	ress of Facility S	ingleton H		
<u>m</u>	89888		MASIL		101220	1	Second	Ave S.W.	Glen Bur	nie, MD	21061
į.			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cau y one cause on eac	sed the death h line.	. Do not ent	er the mode of dy	7) A			Approximate Interval Between Onset and Death
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89	death certificate be executed e attending physician and of for use as the burial-transit			d		-					
Вох	ires that the death certifica signed by the attending ph d be detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnar		Ectopic pregnan	01/		23d. Date of	delivery
о. В	e deal the att	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		t at time of de		Other (specify)			Month	Day Year
Δ.	hat th ed by detach	Phy	Part II. Other significant conditions	contributing to deat	h but not resu	ıltina in the ur	nderlying cause o	iven in Part I	23e. Did tob	acco use contribut	e to the cause of death?
Records,	Attending Physician: The law requires that the sr death. ector: Atter this certificate has been signed by the by the funeral director, page 2 should be detache	d by					,g g		1 ☐ Ye	. /	Probably 4 Unknown
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O	ding h. After funer	tlon	1 Natural 5 Pending 2 Accident investigati		Day Year)	28b. Time of Injury	W	ork? □Yes 2□No	28d. Describe hor	w injury occurred	
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	ie Hospital or Al 24 hours after o e Funeral Direc iletely filled in by	Medical	29a. Certifier (Check only one) 1 Certifying F 2 Medical Example	Physician: To the beaminer: On the basi and manner	s of examinati	wledge, death ion and/or inv	occurred at the restigation, in my	time, date and place opinion, death occ	ce, and due to the car curred at the time, da	use(s) and manne te and place, and	r as stated. due to the cause(s)
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	,		1///	16	10		0	15)5	5/	Jue:	3 2004
	6		30. Name and address of person with	completed cause	of death (Item	23a) (Type,	Horn	fel Din	y I Gran	Dun A	101.2/06/
	Sta		31. Date filed (Month, Day, Year)		istrar's Signat	ure 4	1.			17:	
	Registr	ar	JUN 0 8 200	4		ps p	sporks				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 2004 **Physician** JUNE ARADA C.H. RUSS 4:30 (3 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Saint Joseph Medical Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 4/29/1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Hours Months Min 1 ☐ M 21 F NEBRASKA 171-12-0429 85 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show other traumatic avant, the Medical Ever, a serminal be notified at 1 Yes 2X No Director MD BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 21286 Itams 23a 8203 LOCH RAVEN BLVD. APT. B USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural" WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) YEARS <u>HOMEMAKER</u> OWN HOME 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be FRANK HALL NELL LOGWELL ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 of Health a TIMOTHY RUSS SON 8203 LOCH RAVEN BLVD. APT. B TOWSON MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. 6/8/2004 CATONSVILLE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS /Medical Due to (or as a consequence of): **Examiner** DEEP VEIN THROMBOSIS Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 🗌 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 28a. Dote of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 5 Pending investigation Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 | Homicide within 24 hours a To the Funaral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year) JUN 0 8 2004

29b. Signature and title, of certified

(00)

ER DRIVE. TOWSON. MD 21204 M. D 32 Aegistrar's Signature

Mehla min

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D41410

JUNE OB

2004.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2<u>,</u> RAFFEL JUNE 2004 10:05 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | SEPT. 15 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2₩F 72 Yrs. Director 219-28-8207 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other then "neturel", or Items 23a or 28e-f show 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits ?7 is marked othar then "neturel", or Items 23a or 28e-f show traumatic avent, the Medical Evanirer must be notified at 1 ☐ Yes 2 No Completed by Funeral Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3408 RIPPLE ROAD 21244 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY OFFICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HORNSTEIN MEYER ADA LEVY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If itam 27 is any injury or othar tra STANLEY RAFFEL / HUSBAND 3408 RIPPLE ROAD - BALTIMORE, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/4/2004 *4 ☐ Donation 5 ☐ Other (Specify) BNAI ISRAEL CEMETERY BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. of Funeral Servi 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) End-Stage Parkinsons Onset and Death Disease **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed use as the buriat-transit Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnar 23d. Date of delivery in the past 12 mon 3 Ectopic pregnancy Month 4☐Pregnant at time of death Dav Year 5 Other (specify) P.O. I the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: 25. Was case referred to edical 26. Place Death Check onl one examiner? Other: Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Unursing Home 5 Residence 6 Other (Specify) this funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 Yes 2 No investigation after death 2 Accident 6 Could not be determined 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide within 24 hours a To the Funaral I t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D57465 nescajapaksen.o 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryland 2113 6

DHMH 17 Rev 1/2001

State Registrar

Reisterstown,

25 Main St. Suite 200

32. Registrar's Signature

N.S. Rajapakie MD

2004

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 00 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death Month **Physician** June 1050 PM 2004 /Medical Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner idae Mle M If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 7. Age (In yrs, last birthday) Yrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Number 6. Sex **Funeral** Year) Months Days 220-40-843 1 M 2 Baltimore, MD Director Usuel Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Dapartmant of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23e or 28e-f show any injury or other traumetic event, the Medical Examinating matches notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Bal timore 1 ☐ Yes 2 No Director Varvano 10e. Street end Number 10f. Zip Code 10g Citizen of What Country? Walthel 21234 8800 0. Sil Funeral Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2/XNo If Yes, Give Year or Detes: 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 20 No Specify. Specify: White ۵ 3/2 Widowed 4 □ Divorced Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own laker NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print)) U.J. IV 19b. Mailing Address (Street and Number or Rural Route Nymber, City of Town, State, Zip Code) Way Westminster, MD. 21157 Christine E. Stamm 1160 Canon 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State L⊠Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Veterans Cem. 4 □ Donation 5 □ Other (Specify) Name and Add 21. Signature of Funeral Service License atives funeral + Gremation Ctr MD, 21093 Timonium, se, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Be Completed by Physician/Medical Examiner or Attending Physician: The law raquires that the death cartificate be axecuted use as the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): Director: Aftar this certificata has baan signed by tha ed in by tha funaral director, paga 2 should ba detached Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown roidisn 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 10 NO 1 Tes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Medicai Certification; To 1 Yes 2 No 3□ DOA 4 Narsing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □ Yes 2 □ No investigetion 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral Complataly filled Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Stone 31. Date filed (Month, Day, Year) 32. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar

JUN 0-8 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Reg. No. 2 0 1 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month C 45 **Physician** 06-2004 orothu /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner evindal Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) MARYLAND 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1□M 20 F (a5 220-36-423 Usuel Residence of Decedent Yrs Director filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or itams 23a or 28a-f show nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla artiment of Health and Mental Hygiene. Cortant: If fram a 21s marked other than "naturel; or frams 23a or 28a-1 show injury or other tranmatic event, its Medical Exam. 1 □Yes 2 No BAUTIMORE PARKVIL Be Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No white. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing A ress (Street and Number or Rural Route Number, City or Town, State, Zip Code) 723 MD 21035 Davidsonville Entrepid Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Method of Disposition Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of facility BALTIMORE, MD 21234. 21. Signature of Funeral Service Lio 8800 HHEFORD RD EVANS FUNGKALL HAPEL 23a. Part 1. Enter the pisease, or complications had call shock, or heart millure. List only one hause on ea Approximate Interval Between Onset and Death omplications hal caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Fina disease or condition resulting in death) **Physician** ea /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 hknown 24a. Was an autopsy performed2 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one To Be 21 No 1 Impatient Other: 1 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending Vithin 24 hours after death.

To tha Funaral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and machine as occurred.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier σ_{j} rsoe who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 8 2004

Do Rolly

32 Registrar's Signature

			State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death Reg. No. 2 0 0 0 0 0 0 0 0 0	18114
	Physici /Medio		1. Decedent's Name (First, Middle, Last) William Speight 2. Date of Death Month Day Year 25 29 2004	3. Time of Death
	Examin Funeral Director	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4d. County of Death 4c. County o	She Kes lace (State or Foreign try) Ington, Do
	Maryland a-f show	ctor	10a. State 10b. County 10c. City, Town or Location	0d. Inside City Limits 1 XYes 2 □ No
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examination instituted to incitif of all once.	To Be Completed by Funeral Director	11. Marital Status	an Indian, etc. ack dustry Code) 20748 wn, State
8760, Ba	the burial-transit	icai Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	Approximate Interval Between Onset and Death
P.O. Box 687	t the death certific by the attending p ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. If yes, outcome of pregnancy 1 23d. Date of deliver Month II 23d. Date of deliver Month II 23d. Date of deliver months 23d. Date of deliver mont	Ďay Year
Vital Records,	Physician: The law requires tha this certilicate has been signed i ral director, page 2 should be det	Be Completed by	Cerebral Vascy and Contact of Death (Check only one) 1 Yes 2 No 3 Probation of Death (Check only one)	ably 4 25 nknown osy findings available opletion of cause of 2 No
Division of \	tending Physieath. tor: After this the funeral di	Certification: To	1 Yes 2 Ne Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Hursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Heading a Suicide	
۵	Hospital 24 hours a Funerel I stely filled	ledicai Cei	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Description (Check only one)	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, D 29c. 29c. License number 29d. Date signed (Month, D 29c. 29c. License number	
	1		30. Name and address of person who completed cause of death (Item 23a) (Type. Print) 6188 6 xo 7 Hill Read # 1 Uchech; 7 Official Security m.D 6401 Hill, mp 2074	7e/
	Sta Registr	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 0 8 2004 Shows & Annual	

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of Mary			of Health and of Death		Reg. No 20 (
Physic /Medi		1. Decedent's Name (First, Middle, La	SINGLE				2. Date of De Month	_	3. Time of Death 3:45A
Exami		4a. Facility Name (If not institution, giv	ARIS HOS	PICE	4b. City, T	ym, or Location of De DACTI MI	RE	4c. County o	f Death
Funeral Director		5. Social Security Number 6. S 219 · 28 · 1306 Usual Residence of Decedent	Sex 7. Age (III	10 Yrs. last birthday) 10 Yrs.	If Under 1 Months	Year If Under 24 H Days Hours M		. 1934	9. Birthplace (State or Fore
n the Maryland r 28a-f show	ctor	10a. State 10b. County	10	c. City, Town or Lo	ocation Ti Mor	RE			10d. Inside City Lim
h with the 23a or 28	Funeral Director	10e. Street and Number 3301 WESTE	RWAD	Ave.	10f. Zip C	21218		10g. Citizen of Wi	gat Country?
5-0036 72 hours after death with the Maryland netural, or items 23a or 28a-f show alest Examinat roust be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	r in U.S. 13.	Was Deceder If Yes, specify	nt of Hispanic Origin? v Cuban, Mexican, Pu No Specify:	(Specify Yes or No erto Rican, etc.)	- 14. Race Black Specify:	- American Indian, White, etc.
2121 ad within giene. er than "	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)		dent's Usual (kind of work DO NOT use TECH	done during most of v retired) NICIAN			STRIAL
Maryland 212 d 2 should be filed with th and Mental Hygiene t? is marked other tha treumetic event, Ite.	To Be	17. Father's Name (First, Middle, Last JOHN FOW				18. Mother's N	ARIE É	Maiden Sumame SED FOR	D
≥ ₽ ₹ 5 ₹		19a. Informant's Name/Relationship (FRANCINE JONES 20a. Meylod of Disposition	- ROULHAC	7813	B BIG	of	RIVE KA	NDAUST	WW MD 212
Baltimore, permit. Pages 1 at Department of Heal Importent: If item any injury or othe once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Licer	(y) A	ARBUTUS	CEME 2. Name and	TERY U	11.04 qualtac.	ARBUTUS GREEN	MARYLAND FUNERAL HO UD 21212
Pnysician /Medical Examiner		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause on each line. PULMONARY Due to (or as a co	SARCOID	er the mode of	of dying, such as card	ac or respiratory ar	rrest,	Approximate Interval Between Onset and Death
68760, tificate be executed g physician and as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co						
ords, P.O. Box 68 requires that the death certifica een signed by the attending phould be detached for use as the could be detached	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of p 1 Live birth 2 4 Pregnant at time	Fetal death 3	Ectopic preg			23d. Date Monti	,
rds, P. quires that to signed by	by	Part II. Other significant conditions of	contributing to death but no	ot resulting in the u	nderlying cau	se given in Part I.	10		ute to the cause of death?
Rec he law e has b ige 2 sl	Completed							sy primed? de	ere autopsy findings availat or to completion of cause o ath? Yes 2 \sum No
of Vital Physician: T this certificate ral director, pa	Be (25. Was case referred to medical examiner?	Uses heli			0.1	eath (Check only o	ne)	
ing Phy Miter this	tion; To	1 Yes 2 XNo 27. Manner of Death 1 XNatural 5 Pending 2 Accident investigatio	1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatier 28b. Time o Injury		Other: 4 Nursing Injury at Work? 1 Yes 2 No		lence 6 X Other	(Specify) HOSPICE
in the Control	Certification;	3 Suicide 6 Could not be determined	e Ose Diese of Injury	At home, farm, str Specify)	eet, factory, o	ffice	28f. Location (5 City or Tow	Street and Number in, State)	or Rural Route Number,
Hospitel 124 hours a 19 Funeral I	edical C	29a. Certifier (Check only one) 1 Certifying Pt 2 Medical Exer	nysician: To the best of m niner: On the basis of exa and manner stated.	y knowledge, deat amination and/or in	n occurred at vestigation, in	the time, date and pla my opinion, death oc	ce, and due to the courred at the time,	cause(s) and mann date and place, an	ner as stated. d due to the cause(s)
To the within 2 To the complete	Me	29b. Signature and title of certifier			29c.4L	icense number		29d. Date signed (Month, Day, Year)

a.m.

3:45

JUNE 7, 2004

DORIS SINGLETARY

State Registrar

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. 31. Date filed (Month, Day, Year) **UN 0 8** 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TIMONIUM, MD 21093

			1 - For State Registrar	State of M	laryland / Dep Ce	partment of Fertificate of			ene g. No.2 0 0 4	18116
I	Physici /Medio Examin	al	Decedent's Name (First, Middle WILLIAM 4a. Fecility Name (If not institution)		·)	SPIZLER	or Location of Deat	2. Date of Death Month JUNE	Day Year 4 2004 4c. County of Deat	3. Time of Death 12:59 A M
			2903 FALLSTAFF			BALTIMO			N/A	
	Funeral Director		5. Social Security Number 220–03–2526	6. Sex 1 M 2 □ F	ge (In yrs. last birthda 84 Yrs.	Months Days	If Under 24 Hrs Hours Min.		Year) 9. Birt Co	thplace (State or Foreign buntry) MD
	yland tow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Ba-fat	ctor		I/A	BALTIMO		<u></u>			1 ☐ Yes 2 ☐ No
	with the	Dire	10e. Street and Number 2903 FALLSTAFF	DOAD ADT #	201	10f. Zip Code 21209			g. Citizen of What Co	ountry?
036	pemilt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f ahow any nijury or other traumatic event, it is Modical Examinational by notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	12. Was Decedent Armed Forces ried 1 □ Yes 2 1	t Ever in U.S. 13 ? I No	Was Decedent of his Yes, specify Cub	Hispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or No-	J.S.A. 14. Race - Ame Black, Whit Specify: WHI	e. etc.
Maryland 21215-0036	within 72 ho ene. than "natur he Mudical	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4or	(Giv	edent's Usual Occup re kind of work done DO NOT use retire ANT	during most of wo.	rking	6b. Kind of Business	
2 2	be filed ital Hygi id other event, I	Be Co	17. Father's Name (First, Middle,	Last)	, iEXOII	7111	18. Mother's Nar	ne (First, Middle, Ma		KE
ylaı	should b ind Ments markad umatic e	To B	JACOB	hin (Time Driet)		ZLER	LENA			BLUM
Ma	and 2 st salth and n 27 Is n		19a. Informant's Name/Relations SELMA SPIZLER/						City or Town, State, 2 ALTIMORE M	
Baltimore,	Pages 1 a ment of Hea ant: if itam ury or otha		20a. Method of Disposition 1 XBurial 2 Cremation 4 Donation 5 Other (S	3 □Removal from State	20b. Place of Disj	position (Name of ematory or other da TFTLOH CO	NG. 06/0	Date 20 06/2004 W	Oc. Location - City or 100DLAWN,	Town, State MD
Balt	permit. Departi		21. Signature of Funeral Service	Country Country	۵ 8	22. Name and Addre	ess of FacilitySOL ERSTOWN F	LEVINSON ROAD - PIK	I & BROS., ESVILLE,	INC. MD 21208
			23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause on each	ed the death. Do not e line.	nter the mode of dyir	ng, such as cardiad			Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Chrow Due to (or as	s a consequence of):	PALURE				3 year
	Examiner	ē	Sequentially list conditions, if an, leading to immediate cause. Enter Underlying		A Tewston s a consequence of):	/				20 you
8	sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
8760,	ate hy the	dicai E	rooding in dodiny case	d.	s a consequence of):					
O. Box 6	The law requires that the death certifica te has been signed by the attending pl page 2 should be detached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnance □ Other (specify) □	<i>y</i>		23d. Date of deli Month	very Day Year
rds, P.	w requires that been signed by should be deta	by	Part II. Dther significant condition	ons contributing to death i	but not resulting in the	underlying cause giv	en in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to	the cause of death?
Il Record		Completed						24a. Was an autopsy performe	prior to d	topsy findings available completion of cause of
Vital	aician certific irector	o Be	25. Was case referred to medica examiner? 1 Yes 2 No	Hospital:	2 T F B / O	Oth		ath Check onl one		
Division of	ding PI h. After ti funera	\vdash	27. Manner of Death Natural 5 Pendir Accident investi	28a. Date of Injury	ient 2 ☐ ER/Outpatio ury 28b. Time ay Year) Injury	of 28c. Injur Wor	4 □ Nursing H y at k? Yes 2 □ No	28d. Describe how	ce 6 □Other (Speci injury occurred	ify)
Divisi	To the Hospital or Attanding Phy within 24 hours after death. To the Funeral Diractor: After this completely filled in by the funeral d	Certification;	3 Suicide 6 Could 4 Homicide determ	ined 286. Place of In	ijury - At home, farm, s tc. <i>(Specify)</i>	treet, factory, office		28f. Location (Stree City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	edical (29a. Certifier (Check only one) Certifyir 2 Medical	ng Physicien: To the best Examiner: On the basis of and manner st	of examination and/or i	th occurred at the tir nvestigation, in my o	ne, date and place pinion, death occu	, and due to the cau rred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifie			29c. Licens		29d	. Date signed (Month	, Day, Year)
1	i		30. Name and address of person	who completed assess of	death (Item 23a) (Type		039		6/04/04	
	Q		1 1 1	Woodow 75	2835 Sm		FRAGI	your m	021208	
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 8 2004		rar's Signature	oak				

			. 101	artment of Health and Mental rtificate of Death	Hygiene 004 18117
	Dhunisi		Decedent's Name (First, Middle, Last)	2. Date of Month	of Death 3. Time of Death
	Physici /Medic		RITA	SCHWAGER JUNE	4 2004 7:10 P ^M
	Examin	er	4a. Facility Name (If not institution, give street and number) 45 TATTERSAUL COURT	Ab. City, Town, or Location of Death REISTERSTOWN	4c. County of Death BALTIMORE
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1	If Under 1 Year If Under 24 Hrs. 8. Date 6 Months Days Hours Min. 04/05	of Birth h, Day, Year) 0/1924 9. Birthplace (State or Foreign Country) MD
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Li	ocation .	10d. Inside City Limits
	Mary I sho	tor	MD BALTIMORE REISTERS	-OWN	1 □ Yes 2 □ No
	th the or 28a e noti	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	s 23a	rai	45 TATTERSAUL COURT	21136	U.S.A.
36	hours after death with the Maryland tural; or Items 23a or 28a-f show al Examinational be recitined at	by Funerai	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 🕅 No	Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 ☐ Yes 2 ☐ No Specify:	or No- 14. Race - American Indian, Black, White, etc. Specify: WHITE
2-0	72 hours "natural", dical Era	eted	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working	16b. Kind of Business/Industry
21215-0036	C _ 34	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) CAFETERIA WORKER	BALTIMORE CO. SCHOOLS
<u>ام</u> 2	Hyg Hyg Stha ant.	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, M.	
Maryland	should be nd Mental marked c	ToE	TOBIAS	ASH MAE	GOLDSTEIN
Mar	C			ng Address (Street and Number or Rural Route N MBER WAY COURT REISTER	
ore,			20a. Method of Disposition 20b. Place of Dispo		20c. Location - City or Town, State
Baltimore,	Pages tment of tant: If it			RE CEMETERY 06/07/2004	
Bal	permit. Page Department of Important; if any injury or once.			^{2. Name and Address of Facility} SOL LEVI 200 REISTERSTOWN ROAD -	
	Physician /Medical		23a. Part. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	Ter the mode of dying, such as cardiac or respirate the mode of dying, such as cardiac or respirate the mode of dying, such as cardiac or respirate the mode of dying, such as cardiac or respirate the mode of dying, such as cardiac or respirate the mode of dying, such as cardiac or respirate the mode of dying, such as cardiac or respirate the mode of dying, such as cardiac or respirate the mode of dying, such as cardiac or respirate the mode of dying, such as cardiac or respirate the mode of dying, such as cardiac or respirate the mode of dying, such as cardiac or respirate the mode of dying, such as cardiac or respirate the mode of dying, such as cardiac or respirate the mode of dying, such as cardiac or respirate the mode of dying and the mode of dying and the mode of dying and the mode of dying as a such as cardiac or respirate the mode of dying and dying	Interval Between
4	Examiner		Sequentially list conditions, b.		
	nted Insit	Examine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause, (Disease or injury		
o,	cate be executed physician and the burial-transit		that initiated events c. Due to (or as a consequence of):		
68760,	cate be ohysici the bu	dical			
.O. Box 6	death certif e attending od for use as	Physician/Me		⊒Ectopic pregnancy] Other (specify)	23d. Date of delivery Month Day Year
S, P	sign sign d be	by	Part II. Other significant conditions contributing to death but not resulting in the u		Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
Record	he age	Completed	Paritysmal Athal Fibrillation		Was an 24b. Were autopsy findings available prior to completion of cause of death? es 2 ✓ No 1 ✓ Yes 2 ◯ No
Vital	Physician: T this certificat ral director, pr	Be	25. Was case referred to medical examiner?	26. Place of Death (Check of	only one)
of	Phys this ral dii	To :	27. Manne of Death 28a. Date of Injury 28b. Time of		Residence 6 □Other (Specify) ribe how injury occurred
ion	Attending I or death. actor: After by the funer	atior	1 ØNatural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	
Division	ial or Attendii s after death. al Diractor: A ed in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28f. Locati City o	ion (Street and Number or Rural Route Number, r Town, State)
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, and due to vestigation, in my opinion, death occurred at the t	the cause(s) and manner as stated. ime, date and place, and due to the cause(s)
)	To tha within 2 To tha complet	M	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	15		30. Name and address of person who completed cause of death (Item 23a) (Type,	Business (enter Drive	Reistestown MD 21/36
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	land of	
			1237 0 0 000 1 P	UMAN .	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Gene Bergquist Sward June 2004 0045 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Harford Bel Air
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 TXF Director 091-12-9040 78 Aug. 2, 1925 New York Usual Residence of Decedent desth with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits or 28a-f shov other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a 3641 C Woodsdale Road 21009 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race -American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 € Married Maryland 21215-0036 ö 1 ☐ Yes 2 ☑ No Specify. 3 ☐ Widowed 4 ☐ Divorced "natural", White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mentai Hygiene. important: if Item 27 is marked other than "ne any injury or other traumatic event, the Media 9028. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Public Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Emmanuel Bergquist Anna Marie Klumpp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard H. Sward / Husband 3641 C Woodsdale Rd., Abingdon, MD 21009 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐Donation 5 ☐ Other (Specify) Lakeview Cemeterv 6-9-04 Jamestown, New York 21. Signature / Funeral Service Licenses 22 McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prysician Congesti disease or condition resulting in death) (Oyeans /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to influed at cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner certificate be executed angrene that initiated events attending physician and resulting in death) Last Due to (or as a cons nce of) Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) o been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 3 Probably 4 Dunknown 1 Yes 2 No Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 No 1 Yes 2 @ No 1 Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: P 1 Yes 2 10 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 1 ANatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: the 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funeral C 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 20) 0 Deake Dr. Ste 211 Bel Air MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 520 Osman 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

DHMH 17 Rev 1/2001

Serve

& Sparks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O O Amend Item 23a, 25 per MB, G832,06/01/04dhb Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 12:01 PM **Physician** 2004 chae /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and 4b. City, Town or Location of Death **Examiner** LUJCAA Year If Under 24 Hrs. 641 MOI Cente 7. Age (In yrs. 46 8. Date of Birth Birthplace (State or Foreign Country); last birthday) If Under 1 Sex 120 M 2□ F **Funeral** Days Months Hours 1 Goldsboro, N.C. 243-04 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or 28a-f show the Medical Exactines must be notified at 1 □Yes 20 No timore by Funeral Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 21236 Colleton ours Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Black 1 Never Married 2 Married 1 ☐ Yes 2 No natural, or If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other than *n Elementary/Secondary (0-12) College (1-4or 5+) Force 12 18. Mother's Name (First, Middle .Maiden Sumame 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Ha. uy ဥ nber or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street phiak Balto.MD. permit. Pages 1 and 2: Department of Health at Important: If Item 27 is any injury or other trauonce. 0 ex-wite YO land 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ☐ Burial 2 17 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State 31,2004 21. Signature of Funeral Service Lice artora Part I Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, of heart fallere. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Week abdomina /Medical TOO TED BY MEDICAL EXMINER Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) certificate has been signed by the irector, page 2 should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anticoagulation Therapy (Counadin), Status post Cholecystectomy 23e. Did tobacco use contribute to the cause of death? ģ 3 ☐ Probably 4 @Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed? 1Æ Yes 2□ No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes ZXINO 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this the funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Ď 124 hours after 16 Funeral Dire 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier npletely (Check only one) To the the 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number ertifie 2 28

State Registrar

DHMH 17 Rev 1/2001

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2000 FRAG

32. Registrar's Signature

Surre Drive Bollimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR Stephen Sel 31. Date filed (Month, Day, Year)

JUN 0 1 2004

1. Decedent's Name (First, Middle, Last) 2. Date of Death		10120
Physician	Day Yea	3. Time of Death
Medical George Washington Twigg June 2,		12:10P ^M
4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of De	
8186 Bodkin Avenue Pasadena 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth	Anne An	Birthplace (State or Foreign Country)
Funeral Director 5. Social Security Number 6. Sex 1 M 2 F 88 1 M 2 F 88 1 M 2 F 88 1 M 3 M 3 F 88 1 M 3 M 3 M 3 M 3 M 3 M 3 M 3 M 3 M 3 M	916	MD
Usual Residence of Decedent		T
10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ☐ Yes 2 No
10a. State 10b. County 10c. City, Town or Location MD Anne Arundel Pasadena 10b. Street and Number 10f. Zip Code 10g.	. Citizen of What	
8186 Bodkin Avenue 21122	U.S.A.	Country
MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g.	14. Race - Ar	nerican Indian,
10a. State 10b. County 10c. City, Town or Location MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 21122 11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 Mary 2 Marned 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 10a. State 10b. County 10c. City, Town or Location Pasadena 10d. Zip Code 21122 11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 Mary 2 Mary 10c. City, Town or Location 10g. Street and Number 21 10g. Zip Code 21 12g. Was Decedent of Hispanic Origin? (Specify Yes or No-lify Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 West of Work done during most of working 16l. (Specify only highest grade completed)	Black, Wi	
1 Yes 2 No Specify: 1 Yes 2 No No No No No No No	Specify:	White
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16c. Decedent's Usual Occupation (Specify only highest grade completed) 16d. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16d. Decedent's Usual Occupation (Specify only highest grade completed) 16d. Decedent's Usual Occupation (Specify only highest grade completed) 16d. Decedent's Usual Occupation (Sive kind of work done during most of working life. DO NOT use retired) 16d. Decedent's Usual Occupation (Specify only highest grade completed) 16d. Decedent's Usual Occupation (Specify only highest grade completed) 16d. Decedent's Usual Occupation (Specify only highest grade completed) 16d. Decedent's Usual Occupation (Specify only highest grade completed) 16d. Decedent's Usual Occupation (Specify only highest grade completed) 16d. Decedent's Usual Occupation (Specify only highest grade completed) 16d. Decedent's Usual Occupation (Specify only highest grade completed) 16d. Decedent's Usual Occupation (Specify only highest grade completed) 16d. Decedent's Usual Occupation (Specify only highest grade completed) 16d. Decedent's Usual Occupation (Specify only highest grade completed) 16d. Decedent's Usual Occupation (Specify only highest grade completed) 16d. Decedent's Usual Occupation (Specify only highest grade completed) 16d. Decedent's Usual Occupation (Specify only highest grade completed) 16d. Decedent's Usual Occupation (Specify only highest grade completed) 16d. Decedent's Usual Occupation (Specify only highest grade completed) 16d. Decedent's Usual Occupation (Specify only highest grade completed) 16d. Decedent's Usual Occupation (Specify only highest grade completed) 16d. Decedent's Usual Occupation (Specify only highest grade completed) 16d. Decedent's Usua	b. Kind of Busines	ss/Industry
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The property of the property o	ity or Town, State	, Zip Code)
	, MD 2	1122 [.]
Defination 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Method of Disposition 20c. Place of Disposition (Name of cemetery, crematory or other place)	c. Location - City of	or Town, State
E व व व व व व व व व व व व व व व व व व व		
21. Signature of Funeral Service Licensee		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,		21122 Approximate
shock, or heart failure. List only one cause on each line.	•	Interval Between Onset and Death
Medical disease or condition resulting in death)		/week
		17001
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
Due to (or as a consequence of):		
that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		
We have the past 12 months? O O O O O O O O O O O O O O O O O O O	1	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 5 Other (specify)	23d. Date of d Month	elivery Day Year
1 Yes 2 No 9 Unknown 9 Unknown 1 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown 23e. Did tobace		
	co use contribute	to the cause of death?
Diagram of the Welling 10 Yes	2 XNo 3 1	Probably 4 Unknown
The age of the page of the pag		autopsy findings available
24a. Was an autopsy performed 1 □ Yes 2 1 □ Yes 2 2 1	death?	completion of cause of
24a. Was an autopsy performed to the continuous performed	(10)	
25. Was case referred to medical examiner? 1 Yes 2 Allowed Place of Death Check onlone Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 X Residence 27. Manner of Death 28. Date of Injury 28. Time of 28. Residence	e 6 □Other (Sp	ecify)
28d. Describe how in the control of Death 28d. Death 28d. Describe how in the control of Death 28d. Death 28d. Dea	injury occurred	
Use the position of the positi	tand Number of I	Zum I Cauta Number
27. Manger of Death 1 Natural 2 Accident 28d. Describe how in the plane of line of	tate)	nurar moute ivumber,
293. Certifier 11X Certifying Physician: To the hest of my knowledge death occurred at the time date and place and due to the cause	e(s) and manner a	as stated
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. License number 29d. License number	and place, and du	e to the cause(s)
29b. Signature and title of certifier 29c. License number 29d.	Date signed (Mg/	nth, Dey, Year)
(Ntymae M) Attending Ooctor Da 1654	06/0	4/2004
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OF RIAR - M.D. 8021 RITEM BLOWY, PASADRNA, M	1 2 2 2	
	0 2112	. 4
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		
DHMH 17 Rev 1/2001	 · · · · · · · · · · · · · · · · · ·	
ORIGINAL .		

		-	For	State of N		nd / Dep		of Hea	alth and I	Mental Hy	giene	2004	10	121
			Registrar 1. Decedent's Name (First, Middle, La	st)			inicate.	OI De		2. Date of Dea		_009		of Death
	ysicia		Charles		Α.		Thomas	S		Month JUNE	Day 4th	Year 200		16 AM
	/ledica amine		4a. Facility Name (If not institution, given	re street and number		_			cation of Death			County of Dea		
EX	amme	er e	Union Mem. Hosp		,			ltimo				NA		
Fund	eral		5. Social Security Number 6. S	Sex 7.7	Age (In yrs.	last birthday)	If Under 1	Year If	Under 24 Hrs.	8. Date of Birt	h Yazal	9. Bir	thplace (State	or Foreign
Direc			246-20-4133	1 ⊠ M 2□F	77	Yrs.	Months	Days I	Hours Min.	8. Date of Birt (Month, Day 9-15-	26 rear)	N.		
P.		-	Usual Residence of Decedent		142									
arylaı	펼	_	10a. State 10b. County		10c. Cit	ty, Town or Lo							10d. Inside	City Limits es 2 ☐ No
e 80 1 − 82	9	Sch	Md. NA			Baltin							2.5	
vith th	2		10e. Street and Number				10f. Zip 0				_	en of What Co	ountry?	
ath v	19	by Funeral Director	1934 E. Eager St			0 140		205		7 1		JSA		
ler de	i i	Š	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceder Armed Force 1 Yes 2		.5.	If Yes, specif	y Cuban, A	Mexican, Puert	pecify Yes or No- o Rican, etc.)	'	 Race - Ame Black, White 		
rs aff	E E	S	3 X Widowed 4 □ Divorced	If Yes, Give			1 ☐ Yes 2	No S	Specify:			Specify: E	Black	
ZIZIS-UUSO of within 72 hours after death with the Maryland giene. er than "naturel", or Items 23a or 28a-f show	100	e G	15. Decedent's E	ducation		16a. Dece	dent's Usual	Occupatio	n		16b. Kin	d of Business	/industry	
n i	Med.	Per -	(Specify only highest gri Elementary/Secondary (0-12)	ade completed) College (1-4o	r 5.4)	(Give	kind of work DO NOT use	done durii retired)	ng most of wor	king			,	
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IIIG Z I Z I 3-UU30 be filed within 72 hours after death with the Marylar Ital Hygiene. Ital Hygiene.	vent	Be	17. Father's Name (First, Middle, Last)				18	. Mother's Naп	ne (First, Middle,	Maiden S	Sumame)		
0 5 5 S	O I	0	Alfred		Thoma	s, Sr	•		Lillie	<u> В</u>	ell	Ea	gles	
2 sho and smalls	arm		19a. Informant's Name/Relationship (Туре, Print)		19b. Maili	ng Address (Street and	Number or Ru	ral Route Numbe	r, City or	Town, State, 2	Zip Code)	
- 00 -	other traumati		Jacqueline Myers	Niece					Blvd. A	Apt. 1-T				2121
Ore, jes 1 a of Hec if item	to Jo		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from Stat	. 0	Place of Dispo cemetery, crea	matory or oth	e of er place)		Date		ation - City or		
Pag ment	ri ri		'4 Donation 5 ☐ Other (Special	(y)	Mt	. Zioi	n Cem.		6-9-	-04	Lans	sdowne,	Ma.	
Definit. Pages 1 ar Department of Hea Important: If item	any in		21. Signature of Funeral Service Lice	nsee Wo	عدد		2. Name and March			Balt: 1101 E		e, Md. cth Ave	21202	2
1	2		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus	ed the deat								Approxima	ate etween
Fnysic	ian		Immediate Cause (Final disease or condition			TIC	LUN	G (JANC E	-12			Onset and	Death
/Medi	ical		resulting in death)	Due to (or a						1			-1 yeur	
Exami	ner		Sequentially list conditions	b								3		
σ :	Ŧ .	ne	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or a	s a conseq	uence of):								
The law requires that the death certificate be executed ate has been signed by the attending physician and	trans	Examiner	that initiated events resulting in death) Last	c										
ate be exemply sician a	la I		resulting in death) case	Due to (or a	is a conseq	uence of):								
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leath certificat	e as	Physician/Med	IF FEMALE:	00- 11								1		
Bath cert attendin	or us	an	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1□Live birth	2 Feta	Ideath 3[Ectopic preg				23	3d. Date of del Month	ivery Day	Year
the de	peq .	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□ Unknown		eath 5∟	Other (spec	cify)					,	
that the de			Part II, Other significant conditions	contributing to death	but not res	ulting in the u	nderlying car	ise diven ir	n Part I	23e. Did to	bacco us	e contribute to	the cause of	death?
ires i	۵ ۵	6					meen ying out	acc gircirii				lNo 3∐Pr		
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Vital necolus, sicien: The law requires t certificate has been signer.	90 2	Completed								24a. Was a autop: perfor	SV	24b. Were au prior to death?	itopsy findings completion of	cause of
	r, page									1□ Yes			202 No	
VII.) G	ן מ	25. Was case referred to medical examiner?	Hospital:				Othor	10000-011	th (Check only or				1115
E the sign	<u>=</u>	<u> </u>	1 ☐ Yes 2 ☑ No 27. Manger of Death	1 Mnpa 28a. Date of In		ER/Outpatier 28b. Time of	-	c. Injury at	4 Nursing H	ome 5 Resid			cify)	
ding After	eunj .	5	1 ☑Natural 5 ☐ Pending	(Month, E	ay Year)	Injury	M 200	Work?	2 🗆 No	20d. Describe III	ow injury	occurred		
- c # ::	the :	Ca	3 ☐ Suicide 6 ☐ Could not b	One Olege of I	niury - At hr	ome farm str			20,10	28f. Location (S	reet and	Number or Ru	iral Boute Niu	mher
after Dire	<u> </u>	Certification;	4 ☐ Homicide determined	building,	etc. (Specif	y)	coi, raciory, i	omoe		City or Tow		74071001 01 710	nai nodio ivai	11001,
To the Hospital or Atte	9		29a. Certifier 1 Certifying Pl	nysicien: To the bes	st of my kno	wiedge, deat	h occurred at	the time	date and place	and due to the c	ausa(s) a	nd manner as	stated	
24 h	etely	Medical	(Check only 2 Medicel Examone)	miner: On the basis and manner:	of examina	tion and/or in	vestigation, in	n my opinio	on, death occur	rred at the time, d	ate and p	lace, and due	to the cause((s)
o th	ld li	ğ	29b. Signature and title of certifier	8)			29c. I	License nu	mber	2	9d. Date	signed (Montl	n, Day, Year)	
	0			Compr.	M	D	A	T243	8946	-	iunic	= 4th	2004	}
1	7	-	30. Name and address of person who	completed cause of	death (Item	n 23a) (Tvne	Print)							
-				WA8620				JAL	ATIGZOH	L 801	LTIM	univer	10 212	.18
	State	е	31. Date filed (Month, Day, Xear)	32. Beois	trar's Signa	ure A	men	,						
Re	gistra	r	JUN U O AUUT		1	1	2 44 45							

State of Maryland / Department of Health and Mental Hygieneo 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MAY 26, Day 2004 **Physician** 6:50 PM Than Than /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7 CHAMARAL CT BALTIMORE CO COCKEYSVILLE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 20, 1950 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Director 213-92-0890 54 Yrs. Burma Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Itam 27 is marked othar than "natural", or Items 23e or 28e-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23e or 28e-f show the Madical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Cockevsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Chamaral Court **USA** Completed by Funeral 21030 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Burne 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 02 n/a Domestic Helper Housekeeping Itam 27 is marked othan other traumatic avent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown by informant ဂ Daw Than 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Merrylin Zaw-Mon / Sister 14108 Greencroft Lane, Cockeysville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) May 29, 2004 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1 Donation 5 0 Oper (8 Decity) Baltimore-Washington Crematory Laurel, Maryland Signature I Funeral State Lineage 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 Lowell M. Lemmon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Wound /Medical Due to (or as/a consequence of) Examiner Sequentially list conditions, if any, leading to immediate the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{XOther} \(\text{(Specify)} \) 1X Yes 2 No Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Subject Cut self with circular After 1 Natural 5 Pending 0-0 Yes 2 □ No 2 Accident investigation within 24 hours after deatl To the Funeral Diractor: 6 Could not be determined 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined 288. Place of Injury - At nome, farm, street, factory, office building, etc. (Specify) 288. Location (Street and Number of Rural Routed Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of avanination and/or investigation in my engage death accurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME MAY 27, 2004 (Item 23a) (Type, Print) who completed cause of-death 111 Penn Street, Baltimore, Maryland 21201 0 31. Date filed (Month D 32. Pegistrar's Signature State Registrar

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	partment o			giene Reg. No. 2004	18123
			Decedent's Name (First, Middle,	Last)	-			2. Date of De	ath	3. Time of Death
	Physici /Medio		William E.	Thomas	s, Sr.			Month JU	Day Year NE 4, 2004	04:30 M
	Examir		4a. Facility Name (If not institution, Saint Joseph			4b. City, Tow	n, or Location of De		4c. County of Death Balt	imore
	Funeral Director				ge (In yrs. last birthda 91 Yrs.	y) If Under 1 Ye Months Da		n. (Month, Da	y, Year) Cour	lace (State or Foreign
			Usual Residence of Decedent					Sept. 1	3, 1912 MD	
	nylan how		10a. State 10b. County		10c. City, Town or	Location			1	Od. Inside City Limits
	e Ma	ctol	MD Balt	imore	Cockeys	sville				1 ☐ Yes 2 X No
	or 2	Director	10e. Street and Number			10f. Zip Cod	le		10g. Citizen of What Cour	itry?
	s 23e	ral		Apt. D			21030		USA	
36	be filed within 72 hours after death with the Maryland hat Hygiene. od other then "naturel", or Items 23e or 28e-f show event, the Medical Examinar rust is radified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrier 3 ※ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1 X Yes 2 If Yes, Give Year or Dates:	7	. Was Decedent of the lift Yes, specify C	of Hispanic Origin? (Cuban, Mexican, Pue No <i>Specify:</i>	(Specify Yes or No orto Rican, etc.)	- 14. Race - Americ Black, White, Specify: Whi	etc.
9	2 hou		15. Decedent's	Education	16a. Dec	edent's Usual Oc	cupation		16b. Kind of Business/Inc	dustry
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	e filed til Hygid other vent,	a l	17. Father's Name (First, Middle, La			•		ame (First, Middle,	Maiden Sumame)	
/lar	Mental Mental arked c	To B	John B. Thomas				Pear	l Chenowe	th	
Maryland	2 should to and Ment is marked		19a. Informant's Name/Relationship		19b. Ma	ling Address (Str.	eet and Number or F	Rural Route Numbe	er, City or Town, State, Zip	Code)
	and lealth m 27	1 9	Charles A. Thoma	as/Son				-	, MD 21093	
Baltimore,	ges 1 It of H If ite or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3	☐Removal from State	20b. Place of Disp Dulaney	oosition (Name of ematory or other) Valley	June	Date 28,	20c. Location - City or To	wn, State
ţ	t. Pa rtmen rtent: rjury	17	'4 □Donation 5 □ Other (Spe		Memorial	Gardens	. 20	004	Timonium,	MD
Bal	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked enty injury or other treumatic enty injury or other treumatic.			Michael J.	riagie	O W.Pado	onia Road	Timoniu	aney Valley, m, MD 21093	Inc.
П		Œ.	23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cause by one cause on each I	d the death. Do not enne.	nter the mode of	dying, such as cardi	ac or respiratory ar	rest,	Approximate Interval Between
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	/Medical Examiner		resulting in death)	,	a consequence of):	ghano g g ghana yang yang	t grain g part, part, give, part, g	125 200 1 2 200 200 1	also have been it is their also been been	
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	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			T T K I T \ / I				
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8760,	ficate be executed physician and s the buriat-transit	dical		d						
9	ertifica ing ph e as tl		IF FEMALE:							
Вох	that the death certified by the attending detached for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregna			23d. Date of deliver	ry Dav Year
<u>o</u> .	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant a 9☐Unknown	t time of death 5	Other (specify))		WOOT	Day Feat
<u>a</u>	that the ed by		Part II. Other significant conditions	s contributing to death t	out not resulting in the	underlying cause	given in Part I.	23e. Did to	bacco use contribute to the	e cause of death?
ds,	The law requires that the site has been signed by the bage 2 should be detache	d by	ATHEROSCLEROTI				•	1 □ Y		ably 4 Unknown
Record	w requir s been si should	Completed						24a. Was a	24b. Were autoc	sy findings available
Re	The lav te has age 2	dwo						autop: perfor	sy prior to con meg? death?	pletion of cause of
Vital	rtifica	Φ	25. Was case referred to medical				26. Place of De	1 ☐ Yes eath (Check only or	1	2 No
	ding Physicien: The I n. After this certificate ha funeral director, page	To B	examiner? 1 🗆 Yes 2 No	Hospital: 1 Inpatie	ent 2 ER/Outpatie	ent 3 DOA	Other		ence 6 Other (Specify))
n of	ng Pl		27. Manner of Death 1 ☑ Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry 28b. Time	of 28c. In	njury at Vork?		ow injury occurred	
sio		catl	2 Accident investigat 3 Suicide 6 Could not	he			☐ Yes 2 ☐ No			
Division	l or At after o Direct I in by	Certification:	4 Homicide determine	ad 200. Place Ut III	ury - At home, farm, s c. <i>(Specify)</i>	treet, factory, offic	ce	28f. Location (S City or Tow	treet and Number or Rural n, State)	Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune		29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best	of my knowledge, dea	th occurred at the	time, date and plac	e, and due to the c	ause(s) and manner as sta	ited.
	To the Hi within 24 To the Fi complete	Aedical	5110)	and manner st	ated.				late and place, and due to	
	or with	Σ	29b. Signature and title of certifier	n -m		29c. Lice	ense number	2	19d. Date signed (Month, E	Pay, Year)
ř	(X)	-	, Way	VD,	4		5886		June - 4.	2004
	h'		30. Name and address of person wh	/	eath (Item 23a) (Type	, Print)				,
	Sta	te	31. Date filed (Month, Day, Year) JUN 0 8 200	32. Registr	7601 05Ll ar's Signature	ER DRIV	E, TOWS	ON, MAR	YLAND 2120	4
	Registr	ar	JUN 0 8 200	14 Danie	B	Sporks				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Reg. No. 20 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 20:04 oran Marie June 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** of Maryland University Baltimore Medical Center 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 KF 214-98-9606 Usual Residence of Decedent **Director** filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Itams 23a or 28e-f show the Medical Evantimer must be notified at MD 1 Yes 2 No Funeral Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ISA trenue Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status I □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Xo Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry iring most of working ntary Secondary (0-12) othar than College (1-4or 5+) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe eny injury or other traumatic event, odge. 17. Father's Name (First, Middle, Last) Middle, Maiden Sumam Be 19a. Informant's Name/Relationship (Type, P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100.MD 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, of complications that caused the shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Lymphoblastic Leukemia **Physician** /Medical Due to (or as a consequence of) **Examiner** Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ed by the attending physician and detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Neutropenia Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Vear 4□Pregnant at time of death 5 Other (specify) 9□ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes 2 No After this certificate has been si funeral director, page 2 should it Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 2) No 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Certification: To 1 ☐ Yes 2 X No 1 Nnpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Diractor: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D44052 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S GREENE STREET, BALTIMORE RENAUD THIOMAS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar		State of	f Marylar		artment of H rtificate of I					7 H H Is	18	125
			Decedent's Name (First	t, Middle, Las	it)			7.1.100.10 01 1			2. Date of De			3. Time	of Death
	Physici /Medio		Andre	a Alic	e Torch	ia					Month JUI	NE 6		12	:18a ^M
	Examir		4a. Facility Name (If not in	stitution, give	street and nun	nber)		4b. City, Town, or	r Location	of Death			. County of Deat		. 104
			Gilchrist					Tows					Baltimo		
	Funeral Director		5. Social Security Number 204–58–1005	6. Se	9X □ M 2\10 F	7. Age (In yrs. 38	last birthday, Yrs.	Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da JULY	3, 19	9. Birt Co 965 Per	hplace (State untry) nsylva	
_	pur 🖢		Usual Residence of Deceded 10a, State 10b.	dent County		10c C	ty, Town or L	neation						10d, Inside	City Limite
	faryla •ho	5		N/A		100.0	iy, rountor E								s 2 No
	the Marylan r 28a-f ehow	Director	10e. Street and Number	11/ 17				Baltimor	е	-		10a. Citi	tizen of What Co	untry?	
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	ter death itame 2	Funeral	11. Marital Status		12. Was Dece Armed Fo	dent Ever in U	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Or	rigin? (Spe	city Yes or No) -	14. Race - Ame		
036	within 72 hours after death with ene. Than "natural", or itame 23a or na Modical Examiner must be	þ	1 Never Married 2 3 □ Widowed 4 □ D	_	1 ∐Yes If Yes, Giv Year or Da	2.[ŽLNo <i>e</i>	į	1 ☐ Yes 2 X No	Specify		ilcail, Bic.)		Black, White Specify:	White	
5-0	72 hours "natural",	eted		ecedent's Ed	ucation de completed)		16a. Dece	dent's Usual Occup kind of work done of DO NOT use retired	ation	st of workin	na	16b. Ki	ind of Business/	Industry	
2121	d within giene. ir than	Completed	Elementary/Secondary		College (1	-4or 5+)		DO NOT use retired	1)		.9	Med	dical St	affing	Ţ
12:18AMBaltimore. Marvland 21215-0036	permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, Itla B. ODGe.	To Be C	17. Father's Name (First, Henry Torc								(First, Middle Polly T				
2	shoul nd Me mark	ř	19a. Informant's Name/Re	elationship (7	ype, Print)		19b. Mail	ng Address (Street i						lip Code)	
Z Z	alth a		Sherry A. F	itzkee	/sister			Mud Run 1					PA 1737		
IS AN	es 1 a of He of He filtern		20a. Method of Disposition		Pamayal from 5	Stato	cemetery, cre	osition (Name of matory or other place		Di	ate		ocation - City or		
Z: j	iit. Pagartment ortant: li injury o		`4 □Donation 5 □ C	ther (Specify		Me Me	tro Cre	ematory,	Inc .	6/7/0)4	Ва	altimore	, MD	
(S) = 1.	Deperment important		Dawin	M-WED	onald	na .	Ci 29	Name and Address remation () 9 Freder	Socie ick R	ty of load	Maryl Baltin	and, ore,	Inc. MD 212	28	
97	Pnysician		23a. Part1. Enter the dise shock, or heart failur Immediate Cause (Final disease or condition	ease, or comp re. List only o	olications that ca one cause on e		th. Do not en	ter the mode of dyin	g, such as	cardiac or	respiratory a	rrest,		Approxima Interval Be Onset and	tween Death
Alle	/Medical Examiner		resulting in death)		Due to (or as a conse								1	
	P #	lner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Discase of injury that initiated events	s, ite	b. Due to (or as a consec	quence of):						1		
\- 	xecute and	Examiner	that initiated events resulting in death) Last		c	or as a consec	quence of);								
204	icate be executed physician and s the burial-transit	edical E			d										
' '			IF FEMALE:												
P.O. Box	The law requires that the death certificate has been signed by the attending age 2 should be detached for use as	Physician/M	23b. Was decedent pregr in the past 12 month 1 ☐ Yes 2 ☒No 9 ☐ Unknown	iant		rth 2 ☐ Feta ant at time of o	aldéath 3[Ectopic pregnancy Other (specify)				2	23d. Date of deli Month	very Day	Year
	es that tigned by	by Ph	Part II. Other significant of	conditions co	ontributing to de	ath but not res	sulting in the u	inderlying cause give	en in Part I	l.	23e. Did t	obacco u	ise contribute to	the cause of	death?
C Sp	w requires been sign should be										10	Yes 2	XNo 3□Pro	bably 4	Unknown
REA TORCHIA - OX Division of Vital Records.	sician: The law re certificate has bee irector, page 2 sho	Completed										osy ormed?	24b. Were aut prior to death?		available cause of
TORCHIA of Vital B	iffication, pa	0	25. Was case referred to	medical					26 Place	a of Death	1 ☐ Yes (Check only o	2 No	1 ☐ Yes	2 No	
₩ ×	ysicia is cer direct	O	examiner? 1 ☐ Yes 2 ★ No		Hospital: 1 ☐ II	npatient 2] ER/Outpatie	nt 3 DOA Othe			e 5 ☐ Resid		6 Other (Spec	ity Hos	pico
100	Attending Physician: r death. actor: After this certific by the funeral director,	n: T	27. Manner of Death	Pending	28a. Date of	of Injury h, Day Year)	28b. Time o	f 28c. Injury Work			8d. Describe I			,, [1	
, 4 <u>10</u>	Mtendir death. ctor: Af	catle	2 Accident	investigation			,,		Yes 2□	No					
ANDREA	al or Atten s after deat in Director: ed in by the	Certification:	3 Suicide 6 4 Homicide	Could not be determined	289. Place	of Injury - At h ng, etc. (Speci	ome, farm, st fy)	reet, factory, office		2	8f. Location (3 City or Tov	Street and vn, State)	d Number or Ru)	ral Route Nun	n <i>ber</i> ,
AND	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	edical (29a. Certifier 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	ertifying Phyledical Exam	ysician. To the hiner: On the ba and mann	isis of examina	owiedge, deal ation and/or in	n occurred at the tim vestigation, in my op	ne, date ar pinion, dea	nd place, al ath occurre	nd due to the d at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of	certifier	10			29c. License				_	e signed (Month		
	3		30. Name and address of	person who	completed cau	of death (Ite	m 23a) (Typ <i>e</i> .	2:4				-	e 6, 20	101	
			W.A.R.		GBMC		N-Ch	arles St	. Ba	lto, n	nd 21	205	c		
	Sta		31. Date filed (Month, Da)			egistrar's Sign									,
	Registi	rar	JUN 0	8 2004	1.79	. de	Asar								

Wayne C. Thomas Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04 - 3228State of Maryland / Department of Health and Mental Hygiene For State Registrar AKG Reg. No. 200 L Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Wayne C. Thomas May 12, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner 6401 Baltimore National Pike #184 Catonsville Baltimore County If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug 9, 194 Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 61 Yrs Director 219-40-1623 Maryland Usual Residence of Decedent the Marylend 10a. State 10b. Count 10c. City, Town or Location T is marked other then "natural", or iteme 23e or 28e-f show traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits MD Baltimore Catonsville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? deeth with 59 Walden Mill Way 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married ∏Yes 2∏ No fYes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: à If Yes, Give Tear or Dates: 3 ☐ Widowed 4 X Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "reany injury or other traumatic event. In a Mental Internation of the traumatic event. In a Mental Internation of the Internation Elementary/Secondary (0-12) College (1-4or 5+) mechanical designer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Raymond Earl Thomas Valentina Colorina Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ray Thomas/brother 2 Keesey Road New Freedom, PA 17349 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 X Donation 5 ☐ Other (Specify) 21 Signature of Euneral Avices Licensee Wade Wirector State Anatomy Board 655 W. Baltimore Street 23a. Paul. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Invavial shotgun wound /Medical Due to (or as a consequence of Examiner Examiner The law requires that the death certificate be executed burial-transil Division of Vital Records, P.O. Box 68760 the attending physiclen

Completed by Physician/Medical Be ٩ s after dea,

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certificate

this

within 24 hours a

the Hospitel or Attending Physicien;

Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of):
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
Part II. Other significant conditio	ns contributing to death but not resulting in the underlying cause given in Part I.
25. Was case referred to medical	26. Place of Death (

	200. Did tobacco di	sa continuota to the	Lause (n ueatii!
Į	1 ☐ Yes 2 🛴	No 3□ Probab	oly 4	Unknown
	24a. Was an autopsy performed? 1≰Yes 2☐ No	24b. Were autops prior to comp death? 1 24 Yes 2	y finding pletion o	s available cause of
(C	heck only one)			
ne	5 Residence 6	Other (Specify)	At	scene
8d	. Describe how injury	occurred		

23d. Date of delivery

Day

Year

1:51 P M

1 ☐ Yes 2√∑No

Approximate Interval Between Onset and Death

unk

Certif	4 Homicide
edical	29a. Certifier (Check only one)
ž	29h Signature an

6 ☐ Could not be determined

28a. Date of Injury Found, Day Year) 5 Pending investigation

28b. Time of Con Djury M. 2 2004 1.42 P M 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

motel

Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Hor

subject shot self.

28f. Location (Street and Number or Rural Route Number, City or Town, State) 6401 Bellinge perford like 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b.	Signature	and	title	of	certifi

XXYes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

MA Treesherg

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) May 13, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tasha L Greenber 31. Date filed (Month, Day, Year) State JUN 0 8 2004

M.D 32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

Registrar

PHILLIP AARON UPTON unpend item#23a,27,28a-f,PFR ME,G832,6/22/04eg UNK 04-186 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04 - 3484State of Maryland / Department of Health and Mental Hygiene AKG Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Upton Phillip 23, 2004 May 6:03 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NA 1613 North Chapel Street Baltimore
If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1₩ 2□F Months Days Hours Yrs. 43 Director Md. 218-76-3773 fited within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or Itams 23a or 28a-1 show the Medical Exactive invast be notified at Yes 2□No Director Baltimore Md. NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21218 2100 St. Paul Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ₩ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Varies 12th grade Plummer Department of Health and Mental Princopartment of Health and Mental Princopartment if item 27 is many injury or other any or other any or other an 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Upton B. Louise Marv Robinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3537 Northway Dr., Baltimore, Md. Erica Austin Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Mt. Carmel Cem. 6-7-04 Dundalk, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. 23a. Part 1. Enter the disease, or complications that caused the him Do not start the induce of a sping. Cocaine and Morphine) and Alcohol Intoxication Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last physician and Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 \sum No certificate has page 2 1 Yes 2 ☐ No Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1XXes 2 □ No this At scene 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury Tound nth, Day Year) 28b. Time of **COURT**ry After 5 Pending 1 Natural unknown 1 ☐ Yes 2X No investigation 5/23/04 6:00 ď 2 Accident after death the 6 🛣 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Found: Vacant Brilding 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō 1613 N. Chapel St., Baltimore City, MD Within 24 hours
To the Funeral 29a, Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onal 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and O.C.M.E. May 24, 2004 \mathcal{S}_{ϱ}

State Registrar

30. Name and address of person who comple

11 Depn Street, Baltimore, Maryland 21201

ause of death (Item 23a) (Type, Print)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Year DORETHA WHITE 06 ZIS PM OI 04 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Locetion of Deeth 4c. County of Death MARINER HEALTH BALTIMORE CATONSVILLE CATONSVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Dey, Yeer) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) 1 M 200F 250 58 6952 Yrs. Usual Residence of Decedent 10a. State 10c. City, Town or Locetion 10d. Inside City Limits CATONSVILLE MD BALTIMORE 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1500 FREDERICK AVENUE IJSA 21228 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE. DOMESTIC 12th grade 17. Father's Name (First Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) THOMAS HAMMET FLORENCE, MILLER 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DeNITA SHELL Southvidae Road Balto HD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MD WOODLAWN 00/07/04 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICES the wrupel of 5151 BALTIMORE NATIONAL PIKE BALTO MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBRO VASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? NOXIC 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4D Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28d. Describe how injury occurred

Physician/Medical Examiner ettending physicien and for use es the burial-trensit The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68780 certificate hes been signed by the interector, page 2 should be detached ğ Completed or Attending Physician: Be Certification: To After this

Physician

/Medical

Examiner

Physician

/Medical

Examiner

Funeral Director

Completed by

Funeral

Director

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumstic event, the Medical Examination must be notified at

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	1 ☐ Yes	210 N	lo
27.	Manner of	Death	
	1. Natur	el	5 ☐ Pend

Pending investigation

Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

 Location (Street and Number or Rurel Route Number, City or Town, State) to Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s)

29a.	Certifier	
	(Check only	
	one)	

2 Accident 3 Suicide

4 I Homicide

and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Dey, Year)

24 hours Hospital

To the Hospi within 24 hou To the Funer completely fil

ca

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

CAKHANI, 722 AVE,

ASNEEM 31. Date filed (Month, Dey, Yeer) 32. Registrar's Signature

State Registrar

elu

6 Could not be determined



RJ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? [] [] [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2004 **Physician** June 4, ARTHUR L. 0846 A.^M WILSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Hospital N/A Baltimore City
If Under 1 Year | If Under 24 Hrs. | **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days **X** M 2 □ F 218-72-9568 **Director** Yrs. 12/10/1966 MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at Director 1 Ves 2 No MD BALTIMORE CITY 10e. Street and Number 10a. Citizen of What Country? 0 or itams 23g PRESTON 501 E. ST, APT. #401 21202 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. XNever Married 2☐ Married ☐ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2XNo þ Specify: BLACK 3 Widowed 4 Divorced natural 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry Complete (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CARE PROVIDER SELF-EMPLOYED 12TH othert 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Fisherkad of ARTHUR L. WILSON SR. BETTY SEWELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 20 2 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other trat once. BETTY L. WILSON / MOTHER 501 E. PRESTON ST, APT 401, BALTIMORE, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 6/8/04 METRO CREMATORY BALTIMORE, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AV, BALTIMORE 21207 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tran Box 68760. Completed by Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Vital 2 No Yes 2 No Yes or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check Yes 2 No Hospital: Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) of funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 5 Pending 1 Natural after death. investigation Accident 1sted sed tran in by the 6 Could not be 3 Suicide Flace of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, S., e) determined 4 | Homicide 100 within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) OCME June 5, 2004 who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** MAY 29 2004 9:55 AM WAINWRIGHT GLORIA MAXINE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE 210 N. ALTAMONT AVENUE CATONSVILLE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M XX Yrs. Director 219-22-6756 Usual Residence of Decedent 02/19/1928 76 MD with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Directo BALTIMORE CATONSVILLE MD10g. Citizen of What Country? 10e. Street and Number USA 21228 ALTAMONT AVENUE 210 Funeral Pages 1 end 2 should be filed withIn 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 √Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) FIRST NATIONAL College (1-4or 5+) Elementary/Secondary (0-12) DATA ENTRY BANK OF MD n and Mental Hygie YEARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HESTER COOK ပ WILLIAM EDGAR LANE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 s Department of Heelth ar Importent: If item 27 is any injury or other treu once. 410 SECLUDED POST CIR (H), GLEN BURNIE YVONNE D. ROGERS/DAUGHTER 20c. Location I Dy or Tan. State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 6/3/2004 WOODLAWN, KING MEM. PARK 22. Name and Address of Facility NUTTER FUNERAL HOME 21. Sign of Funer 23a. Part. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. FALLS PKWY, BALTO, MD 21216 Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) worth /Medical Due to (or a / a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit Cause (Disease or injury that initiated events and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, nding physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did topacco use contribute to the cause of death? Completed by alabeles 3 Probably 4 Unknown 1 Yes 2 No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 🗌 Yes 2 🔽 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) he 29b. Signature and tille of certifier 29c., License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) amm 32. Registrar's Signature 31. Date filed (Month, Day, Year, State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Dev Yeer Physician Gwendely Walkers 1:25Am June 2004 /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Wspita Ba Munosia himore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Funeral Days Months Hours 1□ M 2★ F Director 05/13/1929 TN 215-24-7154 Usuel Residence of Decedent permit. Pegas 1 and 2 should be filed within 72 hours after deeth with the Manyland Depertment of Health and Mental hygiana. Important: If item 27 is marked other than "natural", or heme 23a or 28a-f show any injury or other traumetic event, the Medical Exercine must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director MD Anne Arundel Pasadena 10g. Citizen oi What Country? 10e. Street end Number 10f. Zip Code U.S.A. 257 Carvel Road 21122 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-II Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Stetus Black, White, etc. 1 ☐ Yes 2 K No If Yes, Give 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify. Completed by 3 Widowed 4 ☐ Divorced White 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 11 Saleslady Department Store 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Clarence Boyles Anna Doughty 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Larry Walker/Son 257 Carvel Rd., Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem Pk 6/7/4 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, 169 Riviera Dr., Pasadena, MD 21122 23a. Part1. Enter the resease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 3wkg Examiner Physician/Medical Examiner or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Due to (or as e consequence of) pue Division of Vital Records, P.O. Box 68760 ettending physicien lass CAD SIP that initieted events resulting in death) Last Due to (or as e consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown balemakes δ inseshor 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2X No 1 Vos 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medicai Certification: To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Menner oi Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Neturel 2 ☐ Accident 5 Pending nours after death.

neral Director: Aft

y filled in by tha fur investigetion 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours, a To the Funeral Completely filled 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

29b. Signature and title of certifier

31. Date liled (Month,

Radhika Vij

JUN 08

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

W. W.)

2004

105

32 Registrer's Signature

ځ

Inhouse M.D

29c. License number

10053652

29d. Date signed (Month, Day, Yeer)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Dete of Death Month 1. Decedent's Name (First, Middle, Last) Dey Year **Physician** 19ms une 200 /Medical Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 5. Social Security Number Olum If Under 24 Hrs bio If Under 1 Year 8. Date of Birth (Month, Dey, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Months Deys Hours 1 M 2 X F 220-30-0704 02 Yrs. LAND Director JAN. 01 Usuel Residence of Decedent Peges 1 end 2 should be filed within 72 hours effer death with the Marylend nent of Health end Mental Hygiene. and of Health end Mental Hygiene. and: If item 27 is marked other than "natural", or items 23e or 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show iner must be notified at 1 ☐ Yes 2 No HOWARD COLUMBIA **Funeral Director** MARILLAND 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritel Status 2 NO 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ZNo Specify: Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DO MESTIC WORKER 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CHARLES SARAH -INES SR. SNOWDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 20b. Place of Disposition (Neme of cemetery, cremetory or other place)

Date

Columbia, Mp. 2 1044

20c. Location - City or Town, State NEICE GLORIA GARRETT other t 20a. Method of Disposition Depertment of Important: If it any Injury or c 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State AL VARUCEMETERY 66-09-04 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility 21. Signature of Funeral Service Licensee BROWN JR. FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical IMTECT IMAL UBCTRVUTION Examiner Physiclan/Medical Examiner or Attending Physician: The law requires thet the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown INEMONIA Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? FAILURE CONGESTIVE HEART TL Yas 21 No DEMENTIA 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturet 1 ☐ Yes 2 ☐ No within 24 hours efter death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 \(\text{Homicide} \) To the Hospital 29a. Certifier (Check mly one) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. completely 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier 0060560 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) RA. RALTIMORE, MX PANKAJ KHETERPAL NECL 201-109 RIVER BACK 31. Date fited (Month, Day, Year) 32. Registrar's Signature State JUN 0 8 **2**004 Registrar

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Ma		artment of i	Health and M	ental H	200	1. 10100
		ė	Decedent's Name (First, Middle, L.	ast)		ranoute of	Death	2. Date of D	Reg. No. / U	3. Time of Death
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\rangle	Exami		4a. Facility Name (If not institution, g			4b. City, Town,	or Location of Death	June	4c. County of D	
			Joseph Riche	ev Hospice	2	Balt	imore		N/A	
	Funeral		5. Social Security Number 6.	Sex 7. Age	e (In yrs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D	irth 9.1	Birthplace (State or Foreign Country)
	Director		214-64-0387 Usual Residence of Decedent	X 20.	51 Yrs.					Maryland
	land ow		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	death with the Maryland ma 23a or 28a-f show r must be notified at	ţo	Maryland N/A		Bal	timore				XOXYes 2 ☐ No
	or 28s	Directo	10e. Street and Number		Apt.20	2 10f. Zip Code			10g. Citizen of Whal	Country?
	ith wi		501 E. Prest	on Street	Apc.20	212	02		USA	
		Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of I	Hispanic Origin? (Spe pan, Mexican, Puerto f	cify Yes or N Rican, etc.)	o- 14. Race - A Black, W	merican Indian,
36	s afte	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ N	lo	1 ☐ Yes 2 ☐ No		, , , ,	Specify: E	
Ş	within 72 hours after ene than "natural", or ite ne Maulcal Examina		15. Decedent's	Year or Dates:	16a Dece	dent's Usual Occu				
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nd	2 should be filed withir and Mental Hygiene. Is marked other than surmatic event, the M	Be	17. Father's Name (First, Middle, Las	st)			18. Mother's Name	(First, Middle	, Maiden Sumame)	
yla	Mental Mental arked o	ပ္	Emory Jerome	Williams					Johnson	
Maryland 21215-0036	is 1 and 2 should of Health and Men item 27 is marke other traumatic	1 3	19a. Informant's Name/Relationship		19b. Mail	ing Address (Street	and Number or Rural	Route Numb	per, City or Town, State	e, Zip Code)
	1 and 2 Health tem 27		Martha J. Will 20a. Method of Disposition	lams/Motn		-		vu"	parcinor	e,Ma 21239
. jo	8 = 5		1 ☐ Burial 2 ☐ Cremation 3	Removal from State	20b. Place of Dispe cemetery, cre		0/0/	04	20c. Location - City	
Baltimore,	permit. Pag Department Important: I any injury c		* 4 □ Donation X 5 □ Other (Spec	7	Greenmo				Baltimore	, Md
Ba	permit. Departr Importa any inj		Men A		5	240 Rei	sterstow	rman- n Rd	Harris FC Baltimore	neral Home , Md 21215
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R	Physician		shock, or heart failure. List onl Immediate Cause (Final disease or condition	y one cause on each lin	105					Interval Between Onset and Death
	/Medical		resulting in death)	aDue to (or as a	a consequence of):					-
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p.	be executed ician and burial-transit	хаш	that initiated events resulting in death) Last	C. Due to (or as a	a consequence of):					
58760,		aiE			consequence on.					
687		edicai		d						
Вох	death certific e attending p d for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy				23d. Date of d	lelivery
	0 0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at t		∃Ectopic pregnanc; ∃ Other (specify) _	у		Month	Day Year
P.0	that the d ed by the detached	Phys	9 🗆 Unknown	9□ Unknown				11		
	es be	by	Part II. Other significant conditions	contributing to death bu	t not resulting in the u	nderlying cause giv	ven in Part I.		tobacco use contribute	
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of		H- 1	27. Manner of Death	1 ☐ Inpatier	y 28b. Time o	IL 3 DOA	4 Nursing Hom		dence 6 X ther (Sp how injury occurred	pecity) #55/1CE
ion	Attending Property of the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury		k? Yes 2∐No		,,	
Division	r Attendi er death. rector: A by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not determined	28e. Place of Injur	ry - Al home, farm, str . (Specify)	eet, factory, office	28	Bf. Location (Street and Number or I	Rural Route Number,
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	Z Medical Exa	hysician: To the best of miner: On the basis of	examination and/or in	h occurred at the tir	me, date and place, ar	nd due to the	cause(s) and manner a	as stated.
	thin 2 the the mplet	Med	one) 29b. Signature and tille of certifier	and manner stat	ted.					
	N T S	-	Yan O	2-0		29c. Licens			29d. Date signed (Mor	
	2		20 Name and address to account	my, M.1	outh (Itam 32a) T	UX a	488		June G,	2004
	0		30. Name and address of person who	completed cause of de	1. D , 25	77/1/	ARINGE !	OAKA.	BALTHA	2004 U. M. 21212
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	r's Signature	paids	Marie L	2014/	ONTITUDE	1. my 2/2/2
	Registr	ar .	JUN 0 8 2004	1	1- 17					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #8State of Maryland / Department of Health and Mental Hygiene 1 = State Registrar AMEND IEM #1 PER PHY G832 6 Pertificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death PAULETTE S. WATSON Physician Month 1000 M Patricia Shirley Watson JUNE 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death St. Agnes Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7-10-1939 rthplace (State or Foreign (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**X**□ F Months Days Hours Min Yrs. 66 Director 220-56-1242 Maryland Usual Residence of Decedent with the Maryland 10a, State 10c. City, Town or Location r than "natural", or Itams 23s or 28a-f show the Modest Examinar must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death v 3319 Kessler Court Funeral 21227 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If itam 27 is marked other than any injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael S. Lipman Lena Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julie Watson-Fuerte Daughter 604 Fifth Avenue, Lansdowne, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ACremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory, Inc. 6-7-2004 Baltimore, MD Sign Ture of Funeral Service License 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PNEUMONIA Immediate Cause (Final disease or condition resulting in death) **Physician** 24 HOURS /Medical Due to (or as a consequence of): Examiner CHRONIC KIONEY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of). Examiner burial-transit the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Physiclan/Medical 38 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day vatson, laulette 4□Pregnant at time of death 5 ☐ Other (specify) Year 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ OAGULOPATHS 1 Yes 2 No 3 Probably 4 Unknown Completed SEPTIC SHOCK 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 X No this certificate has 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury Medical Certification: 28d. Describe how injury occurred After Natural 5 Pending within 24 hours after Control To the Funeral Director: Aft investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide Descripting Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JUNE 04 2004 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVENUE SARUMI ST AGNES HOSPITAL BALTIMORE MO 21229

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State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUN 0 8 2004

State of Maryland / Department of Health and Mental Hygien 2 0 0 4

18135

Physician	
/Medical	
Examiner	

Fur Dire

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 Is marked other then *neturel; or Items 23e or 28e-f show

Baltimore, Maryland 21215-0036

Physi /Med Exam

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760,

		1 - For State Registrar	State of Ma	Ce.	rtificate of	Death		g. No.	10133		
ysici Medic		1. Decedent's Name (First, Middle, La Roy Ryland Wolfo					June 4,		3. Time of Death 11 P. M		
amin	er	4a. Fecility Name (If not institution, giv 856 Gaming Squar			4b. City, Town, or Location of Death Hampstead 4c. County of Death Carroll						
eral ector			Sex 7. Age XIXM 2□ F 5	(In yrs. last birthday) 8 Yrs.	If Under 1 Year Months Days		8. Date of Birth June 17	9. Bir , 1945 Mar	nthplace (State or Foreign ountry) Cyland		
lified at	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10c. C									
at be no	al Director	10e. Street and Number 856 Gaming Squar	e		10f. Zip Code	21074	10	g. Citizen of What Co USA	ountry?		
eny injury or other treumstic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2XMarried 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	D	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2X No	Hispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:Whi	te, etc.		
ledical	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most of worki	ing 1	6b. Kind of Business	Andustry		
it, the N		Elementary/Secondary (0-12)	College (1-4or 5+	San	itation			Private in	ldustry		
itic ever	To Be	17. Father's Name (First, Middle, Last) Roy Ryland Wolford, Sr. 18. Mother's Name (First, Middle, Maiden Sumame) Mary Crisafulli									
er treuma		19a. Informant's Name/Relationship (Type, Print) Marjorie Wolford Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 856 Gaming Square Hampstead, Maryland 21074									
y or othe		20a. Method of Disposition 1 1 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State									
eny injui once.		21. Sign two Funeral Service Linear fee Years 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland									
as the burial-transit	Medical Examiner	23a. Part1. Enter the disease, or com shock, for heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	aDue to (or as a bDue to (or as a c	consequence of): consequence of): consequence of):	Inc	nter	ر ا		Approximate Interval Between Onset and Death		
completely filled in by the funeral director, page 2 should be detached for use as i	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of del Month	livery Day Year		
ld be det	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of the ca									
page 2 shoi	Completed						24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of		
director,	o Be	25. Was case referred to medical examiner? 1 Yes 2	Hospital: 1 ☐ Inpatien	t 2 ER/Outpatier	it 3□ DOA Ott	26. Place of Death	1	ice 6 Other (Spec	cify)		
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oletely fills	edical	29a. Certifier (Check only one)	nysician: To the best of niner: On the basis of e and manner state	examination and/or in	occurred at the tile vestigation, in my o	me, date and place, a opinion, death occurre	and due to the cau ed at the time, dat	ise(s) and manner as e and place, and due	stated, to the cause(s)		
comp	X	29b. Signature and title of certifier		4 (I) - 22) T	29c. Licens	se number		Date signed (Month	n. Day, Year) 200 Y e MJ 2/2/7		
'		30. Name any ddress of person who	Far 3	N EEE	onth c	is heat s	meet	Baltinon	e MJ21218		
Sta egistr		31. Date filed (Month, Day, Year) JUN 0 8 2004	32. Registrar	's Signature	Sporks						
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DHMH 17 Rev 1/2001

Registrar

-03779		Out (Mandard D		
Ŋ		1 - State	partment of Health and Mental Heartificate of Death	ygiene Reg. No.2004 18136
		Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of D	Death 3. Time of Death
Physic		Valerie Mildred Wrightson	June	06, 2004 Year 1640 P M
/Med Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
		2513 Michels Lane	Parkville	Baltimore
Funera	_	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min. (Month, L	Day, Year) Country)
Director		213-12-9550 87 Yrs. Usual Residence of Decedent	December December	er 23, 1916 MD
yland how		10a. State 10b. County 10c. City, Town or L	ocation	10d. fnside City Limits
e Mar	ctor	MD Baltimore Parkvill	_e_	1 □ Yes 2 No
vith th	Dire	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
eath v	erai	2513 Michels Lane 11 Marital Status 12. Was Decedent Ever in U.S. 13.	21234 Was Decedent of Hispanic Origin? (Specify Yes or N	United States 14. Race - American Indian,
fter d	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Bfack, White, etc.
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 77 is marked other than "neturel", or Items 23a or 28e-f show treumatic event, the Medical Evantiner must be notified at	þ	3 Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2X No Specify:	Specify: White
5-0 72 hc	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
Mithin within the mithin the Me	mpi	Elementary/Secondary (0-12) Colfege (1-4or 5+)	Secretary	Clerical
d 2 filed Hygie other	CO	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd	
land be ental	ToB	Eugene Eichelberger	Mildred Sch	rimger
ary	1	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rural Route Num	
			21 Regwood Road, Hydes, Nosition (Name of Date	
Baltimore, bernit. Pages 1 ar Department of Hea mportant: If item any injury or othe		Tabunar 2 Commation 3 Enemovarium State	natory or other place)	20c. Location - City or Town, State
Itin artmer ortant injury		21 Signature of Fundal Service Ligensee	/ALIEY MEM. GIGHS	Timonium, Maryland
Dan permi Depa Impo		S.Coster 1	1050 York Rd. Towson, MD	wsph ₂ 54neral Home, Inc.
		23a. Part1. Enjer the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		
Physician		Immediate Cause (Final disease or condition	on	Onset and Death
/Medical Examiner		resulting in death) Due to (or as a coasequence of):	0 1 0-1 1	
LAdimilei	-2	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	+ left leg	
iled insit	Examiner	Cause (Disease or injury	,	
D, exect an and rial-tra	Exa	that initiated events c. The sulting in death) Last Due to (or as a consequence of):		
8760, rate be executed hysician and the burial-transit	icai	C d		
8 g a	Physician/Medic	IF FEMALE:		
Geath certific death certific e attending pod tor use as	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)	23d. Date of defivery Month Day Year
	ysic	1 Tes 2 No 9 Unknown 9 Unknown		
Records, P.O. Box The law requires that the death cer te has been signed by the attendin age 2 should be detached tor use	by Pł	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I. 23e. Did	tobacco use contribute to the cause of death?
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The The cate h	Con	lypertension	per 1 Yes	formed? death? 2 □ No 1/2 Yes 2 □ No
Vital sicien: T certificat rector, pa	Be	25. Was a e referred to medical examiner? Hospital:	26. Place of Death (Check only	
VISION Of VITA Attending Physicien: or death. ector: Atter this certific by the funeral director.	n: To	1	all 30 DOX 40 Not sing Home 30 116:	sidence 6XOther (Specify) At SCENE s how injury occurred
ISION Attending death. ctor: Atte	atio	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	M 1 Yes 2 No Subje.	tivined leftles
Division of or attending Phy after death. Director: After this in by the funeral d	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		(Street an Number or Rural Route Number, own, State)
Ditel of urrs af prel Diffed ii		29a. Certifier 1 ☐ Certifying Physicien: To the best of my knowledge, deal	tone 2513	Mirkels lone 4234
Division of Vital Re To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	edicai	29a. Certifier (Check only Amal 2 Medicel Exeminer: On the bast of my knowledge, deal 2 Medicel Exeminer: On the basts of examination and/or in and manner stated.		
To the within To the compl	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
•		(Cakem)	O.C.M.E.	June 07, 2004
1		30. Name and address of person who completed cause of death (Item 23a) (Type,		_
	oto	31. Date filed (Month, Day, Year) 32. Registrar's Signature	11 Penn Street, Baltimor	e, Maryland 21201
Regis	ate trar	JUN 0 8 2004 Senter B	park	

	1	For State Registrar	State of Mar	yland /				lealth a Death	and M	-	giene Reg. No.	-20	04	18.13
Physicia /Medica	n	1. Decedent's Name (First, Middle, Las Francis A. Weig								2. Date of Dead Month	Day 3	,20	(ear 004	3. Time of Death
Examine Funeral	er	4a Facility Name (If not institution, give Franklin Sq. 18. Social Security Number 6. S.	re Hospit	In yrs. last	birthday) Yrs.	4b. City, If Under	20°	Location of Landar If Under Hours	le	8. Date of Birt (Month, Day Feb 24		Ba	Hin 9. Birthpl Coun	
Director		212-05-4985 Usual Residence of Decedent 10a. State 10b. County		89 10c. City, T	1	cation		and the second		Feb 24	, 19	15		yland Od. Inside City Limits
r 28a-f sh anutified	irector	MD Baltimo:	re		Balti	lmore					10g. Citi	izen of Wh	nat Coun	1 ☐ Yes 2x No try?
0 2	by Fur	8810 Walther Blvc 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 #2404 12. Was Decedent Ev Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:			Vas Deced I Yes, spec	dent of H cify Cuba	234 ispanic Ori an, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	-	USA 14. Race Black, Specify:	White, e	
giene. er than "natur t, the Medical I	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)		life. L		rk done i se retired	during mos d) er			gas	ind of Bus	lect	
Mental Hy arked oth atic event	To Be	17. Father's Name (First, Middle, Last) Frank Weigs						Cat	heri	e (First, Middle, ne Lucy	Ker	ndall		· · · ·
ent of Health and it: If item 27 is m y or other traum		19a. Informant's Name/Relationship (Charles Weigand/s 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ '4 ☒ Donation 5 □ Other (Specification 1)	Removal from State	20b. Place		Cross	e Po	int R	oad	al Route Numbe Abingdo Date	n, M		1009	
Departm Importar eny injui		21. Signature of Euneral Service Licer KONALO S		ctor	S	Name ar tate alti	Ana	ss of Facilit	Boar ZIZ	d 655 W	. Ва	1tim	ore.	Street
ysician Medical taminer		23a. Part Enter the disease or com- shock, in heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Ospiva	TION consequen	Pries	umav		g, such as	cardiac d	or respiratory ar	rrest,			Approximate Interval Between Onset and Death
	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a composition of the composition o	consequent CG/ consequen	g piv	ie C		oph		5				
ed by the attending prodetached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at til	Fetal de	ath 3]Ectopic p] Other (sp		<u>'</u>				23d. Date Mont		ry Day Year
igne be d	þ	Part II. Other significant conditions of	contributing to death but	not resultin	ng in the ur	nderlying	ause giv	en in Part I		23e. Did to	Yes 2	2No 3	□ Proba	e cause of death? ably 4 Unknowledge of the control of the cause of death?
ate has page 2	e Completed	25. Was case referred to medical						OS Place	of Dogst	autop	osy rmed? 2 No	de	or to con ath? Yes	npletion of cause of
	0 8	examiner?	Hospital:	2∏FR	/Outpatien	t 3 D	Oth	90		me 5 Resid		6 □Other	(Specify	·)
5 -	Certification; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b	28a. Date of Injury (Month, Day	Year) 28	8b. Time of Injury	М	28c. Injur Wor 1 🗀		No	28d. Describe h	how injur	y occurred	d	
urs after death		4 Homicide determined	building, etc.	(Specify)						City or Tov	vn, State) ::::::::::::::::::::::::::::::::::::		Route Number,
within 24 hours after To the Funeral Dir cumpletely filled in	Aedical	(Check only 2 Medical Examone)	nysician: To the best of niner: On the basis of e and manner state	examination		vestigation	n, in my d	pinion, dea		red at the time,	date and	d place, an	d due to	the cause(s)
S F 0	Σ	29b. Signature and title of certifier)—————————————————————————————————————			1) 611x				3-d2	Tung	200	Day, Year)
Sta		30. Name and address of person who 31. Date filed (Month, Day, Year)	32. Registrar	uwKli	N 30	Print)	Da	ive,	Bak	tive	M	D. 3	133	17

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 19b State of Manyland (Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Williams **Physician** JUNE 0 raan /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (# hot institution, give street and number) Examiner DANS DITA If Under 24 Hrs last birthday) Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** Months Days Hours 10 M 2□F Director the Maryland 10a. State 10b. County City, Town or Location 10d. Inside City Limits 28a-f ahow Examiner must be notified at 1 Yes 2 □ No Director 10g. Citizen of What Country? Street and Number 10f. Zip Code with ō Items 23a Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 end 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐Yes 2 XNo lore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☐No Specify. If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry traumatic avent, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) al Hygiene. ectricia 18. Mother's Name (First, Middle. (First, Middle, Last) Be f Heelth and Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, tate, Zip Code) adra BaltOMD V205 Melowilliams other 20a Method of Disposition permit. Pages 1
Department of H
Importent: If Ite
any injury or oti N Burial 2 ☐ Cremation 3 ☐ Removal from State
14 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician das disease or condition resulting in death) Trace /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed otherosche and Due to (or as a consequence of): vision of Vital Records, P.O. Box 68760, attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be 3 Probably 4 ⊠Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA ٩ this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) determined 4 Homicide Fo the Hospitel 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Ijem 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

Street

marke

N Wolfe

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 6 4b. City, Town, or Location of Death 4c. County of Death Date of Birth (Honth Day, Birthplace (State or Foreign
 Country) Days Min al Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) during most of working (Give kind of work done life. DO NOT use retire Elementary/Secondary (0-12) College (1-4or 5+) (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) or Town, State, Zip Code) ethod of Disposition 20c. Location - City or Tow 1 ■Burial 2 □ Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ardiac disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE

Physician /Medical

Physician

/Medical

Examiner

10a. State

Director

Funeral

ģ

Completed

Funeral

Director

"neturel", or Items 23e or 28e-1 show

or other traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "ne any injury or other traumatic event, the Madic once.

filed within 72 hours after

Baltimore, Maryland 21215-0036

Examiner

Physician/Medical Completed by Be

use as the burial-transit requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-trar To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica

Examiner

Division of Vital Records, P.O. Box 68760

State Registrar

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

1 ☐ Yes 2 ☐ No

9 Unknown

in the past 12 months?

25. Was case referred to medical

2 NO

5 Pending

investigation

6 Could not be determined

examiner?

1 Tes

27. Manner of Death

2 Accident

3 Suicide

4 Homicide

1 Matural

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 2 Fetal death 4 Pregnant at time of death 9 Unknown

1 Inpatient

3 Ectopic pregnancy 5 Other (specify)

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

23d. Date of delivery Month

3/0

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

2 No

Year

24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 1 Yes 26. Place of Death (Check only one) 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify)

28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other:

29a. Certifier 1 🔾 critifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

2 ER/Outpatient 3 DOA

28b. Time of

mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

> Rollin Surte N. Rd 32. Registrar's Signature

31. Date filed JUN. Bay 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 la 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Yeer **Physician** une /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner N Ba NUISING MOUNT 9709 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, **Funeral** 212-80-9440 Days Hours Min 1 M 20 F Soul Yrs June 6,192 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State or 28a-f show Health and Mental Hygiene. Iom 27 is marked other then "natural", or Items 23s or 28s-f ehov other traumatic event, the Medical Examinar minal be notified at TIMORE Timonium 1 Tes 2 No Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 21093 Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specity: Korean Baltimore, Maryland 21215-0036 If Yes, Give "Year or Dates: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) condary (0-12) tome N 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be BOK Par 200 NO မှ 19b. Mailing Address (Street and Nymber or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Flace Timonium, Khodes Son item 27 JOK 20b. Place of Disposition (Name of Date 20a Method of Disposition permit. Pages 1
Department of F
Important: If ite
any injury or ot
ance. Burial 2 Cremation 3 Removal from State Valley Mem. Gad. 6 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenda 23a. Per 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or conditions) Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as sequence of) Examine The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day Month Year in the past 12 months? detached for 4 Pregnant at time of death 5 Other (specify) ☐Yes 2. No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed 4 Dunknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 280 No 1 Yes 1 Yes 2₽ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۲ 1 🗌 Yes 2 (X) No 1 Inpatient 2 ER/Outpatient 3 DOA this

Division of Vital Records, P.O.

State Registrar

filled in by the funeral

After t

death.

within 24 hours after deat To the Funerel Director:

Medical Certification:

31. Date filed (Month, Day, Year) JUN 08

29b. Signature and title of certifier

27. Manner of Death

1 Natural

2 Accident

4 - Homicide

3 Suicide

29a, Certifier (Check only one) 5 Pending investigation

6 ☐ Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

32. Registrar's Signature

28a. Date of Injury (Month, Day Year)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Rockulle MD Zeffo

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License numbe

1 ☐ Yes 2 ☐ No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ALLEN AYERS Month 10.40 AM **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE BALTIMORECITY VAIRECC If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 11 1 30 Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral X**XM 2□ F Yrs 72 MD Director 218-28-1620 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits the Maryland "natural", or items 23a or 28a-f show olical Examiner must be notified at Yes 2 No Baltimore MD NA Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2811 Brighton Street 21216 U.S.A Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1**X** Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Social Security Adm Lead Clerk 12th grade na and Mental Hygie Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth Hite Henry Ayers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tre-2811 Brighton Street, Baltimore Nd Elsie M. Ayers-Wife 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State **Eurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Vet. 6/11/04 Owings, Mills, Md 21. Signature of Juneral Service License 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore Md 21215 Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Carcinoma **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause pusease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. disease etive 1 Ves 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 21 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Unursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 DNO Certification: To nours after death.

nerel Director: After this y filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Intury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funerel C 1 critifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6.6.06

State Registrar

DHMH 17 Rev 1/2001

JUN 0 9 2004

31. Date filed (Month, Day, Year)

32. Fegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type

ORIGINAL

YSF.	IIKA ASI	ΧIN			artment of Health and Natificate of Death		ene 	1811.2
			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physic		Tyshika Askins			June	7, 2004	13:30 M
}	/Medi Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
			2339 Hudson Road Apartmen	t 302	Cambridge		Dorches	ter
	Funeral		5. Social Security Number 6. Sex 7. Ag 2 1	e (In yrs. last birthday) 22	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) Aug. 23,	9. Birthr	place (State or Foreign htry)
	Director		220 90 1190	ZZ Yrs.		Aug.23,	1981 MI)"" =
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			0d. Inside City Limits
	danyi f sho	ō	MD Dorchester	Cambridg	e			1 Yes 2 No
	the 1	rect	10e. Street and Number	1	10f. Zip Code	100	g. Citizen of What Cour	ntry?
	3a or	D	2339 Hudson Road Apartm	nent 302	21613		United St	
	72 hours after death with the Maryland neturel', or Items 23a or 28e-f show oral Examinat must be notified ut	Funeral Director	11. Marital Status 12. Was Decedent	Ever in U.S. 13. \	Use Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	
9	after or ite	Ē	Armed Forces? 1 Never Married 2 Married 1 Yes 2 1 If Yes, Give	No.	r Yes, specify Cuban, Mexican, Puerto I □ Yes 2 No Specify:	Hican, etc.)	Btack, White,	_{etc.} ack
8	ours irel',	db	3 Widowed 4 Divorced Year or Dates:		TO 165 ZEINO Specily.		Specify: BI	ack
21215-0036		Completed by	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupation kind of work done during most of work	ing 16	6b. Kind of Business/In	dustry
12	within ene. than "	E G	Elementary/Secondary (0-12) Coltege (1-4or 5		DO NOT use retired) EDICINE AIDE		Nursing	Home
	filed Hygir Sther	ပို	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, Ma		
an	id be ental ked c	To Be	Kenneth Alvin Askins			Denise		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heatih and Mental Hygiene. Importents if item 27 ie marked other than "neturel", or items 23a or 28e-f show any injury or other treumatic event, if e Madical Examinal must be notified at 2008.	-	19a. Informant's Name/Relationship (Type, Print)	19b Mailin	g Address (Street and Number or Run	al Route Number, (City or Town, State, Zip	Code)
	and 2 saith a n 27 ic		Diane Green-Mother	Cambr	g Address (Street and Number or Run Cambridge Belt idee Maryland	way Apt	. 6	
S.	of He		20a. Method of Disposition 1 Disposition 3 Removal from State	20b. Place of Dispo	sition (Name of natory or other place) June	Date 1 2	oc. Location - City or To	wn, State
Ĕ	Pa Pa		'4 □Donation 5 □ Other (Specify)		ME Church 20	04	ambridge,	MD.
Baltimore,	permit. Departr Importe any inju		21. Sign ture Funeral Service License	C ²²	Name and Address of Facility 1 i a	ms Fune	ral Serv	ice P.A.
Ш	20229		Cour & Tha	P	Name and Address of Facility 1 Vin L. Willia .O. Box 11651 E	Balto. M	iD. 21229	
	Pnysician /Medical Examiner			10.	Services 1	For CE	INTURIES	Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	dical Examiner	cause. Entire Underlying Cause (Disease or injury that initiated events c.	a consequence of): a consequence of):				
P.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year
Vital Records, P	quires tha en signed I uld be det	by	Part II. Other significant conditions contributing to death be	ut not resulting in the ur	derlying cause given in Part I.		cco use contribute to th	e cause of death? ably 4 Unknown
၀	aw requii s been s 2 should	Completed				24a. Was an		osy findings available
Ä	The taw ate has page 2 :	E				autopsy performe 1 Yes 2	d? death?	npletion of cause of 2□ No
ita	icien: Th certificate rector, pag	Be C	25. Was case referred to medical		26. Place of Death		110 121100	20110
of V	S S D	2	examiner? 1 Yes 2 □ No Hospital: 1 □ Inpatie	nt 2 ER/Outpatient	3 DOA Other: 4 Nursing Ho	me 5 Residenc	ce 6 Nother (Specify	SCENE
0		:uo	27. Manner of Death 1 □Natural 5 □ Pending (Month, Day	Year) 28b. Time of Injury	28c. Injury at	28d. Describe how	injury occurred	AND BEATEN
Division	Attending r death.	Certification:	2 Accident investigation 3 Suicide 6 Could not be	04 1:20 P	M 1 ☐ Yes 2 ☑ No	SUBJECT S	STRANGLED I	NO DEFIELD
Σ	l or Atteno after death Director: I in by the	Ħ	4 Homicide determined 28e. Place of Inju-			City or Town, S		- A M & 0101 F
	pitel urs a eral C		COn Conflict 4 Confident Physician T 11 L 1	RESIDENC			ow Ro, Apt 30	CH LD
	Hos 24 ho Fun	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the bast of and manner sta	examination and/or inv	occurred at the time, date and place, a estigation, in my opinion, death occurred	and due to the caused at the time, date	se(s) and manner as sta and place, and due to	ated. the cause(s)
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	Med	29b. Signature and title of certifier		29c. License number	29d	. Date signed (Month, L	Day, Year)
	⊢ ≯ ⊢ ŏ		Donatt .		O.C.M.E.		June 08, 20	
	À:		30. Name and address of person who completed cause of de	eath (Item 23a) (Type. F				
	1/		ANA RUBIO, A	10 4 111	Penn Street, Bal	timore, M	Maryland 21	201
8	Sta Registr		JUN 0 9 2004	rs Signature	J			

			State of Maryland	/ Department of Health and M Certificate of Death	•	ne 2004 1811.3
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici		Audres Vivian Austin			Day Year 235 PM
3	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	LAdillii	C1	GOOD SAMARITAN HOSPITA	AL BALTIMORE	-	Na
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last		8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
1	Director		216 30 5362 10M 20F 74	Yrs. Moritis Days 110013	April 10,1	1930 M.D
	p .		Usual Residence of Decedent 10a. State 10b. County 10c. City, T	own or Location	<u>`</u>	10d. Inside City Limits
	show	_				Yes 2 No
	88-1	octo		14mine	100	Citizen of What Country?
	vith t	Director	10e. Street and Number	10f. Zip Code 2/239	Tog.	U.SA
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23s or 28s-f show aumatic svent, the Marylas Expeditor must be notified at	by Funerai	640 Lechkaver Blvd 11 Marital Status 12. Was Decedent Ever in U.S.		acify Yes or No.	14. Race - American Indian,
	er de Item	nu	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No	13. Was Decedent of Hispanic Origin? (Spi If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Bfack, White, etc.
36	rs aft	by F	3 Avidowed 4 Divorced Year or Dates:	1 ☐ Yes 2 🗹 No Specify:		Specify: Black
5-0036	"natura "natura			6a. Decedent's Usual Occupation	168	b. Kind of Business/Industry
15		piet	(Specify only highest grade completed) Efementary/Secondary (0-12) Coflege (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	ing	
2121	d within giene. rr then "	Completed	12	Hem marked		40 MeiNAICEL
	e file of the vent,	ВеС	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	
<u>la</u>	Aental Aental rked c	To E	William REE	Pannie 19b. Mailing Address (Street and Number or Rura	DYER	
Maryland	and A		19a. Informant's Name/Relationship (Type, Print)			
Σ	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any njury or other traumatic avent. If a MDGB.	١.,	CAN PURKETE	3106 WEAVER AVE BA	Homens 1	AD 2/3/7 c. Location - City or Town, State
Baltimore,	of He		20a. Method of Disposition 1 ☐Burial 2 ☐Cremation 3 ☐Removal from State	etery, crematory or other place)		
Ĕ	Page nent int: I		· 4 Donation 5 Other (Specify)	22. Name and Address of Facility Be	104 1	BA HIMERE 110
ati	permit. Pag Department Important: sny injury once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	ts Famen	1 Home
B	Per		Talian But	1124 N CARHINE	s.+ 3p14	ment, 40 71213
>	Physician /Medical Examiner		Due to (or as a consequent	ARY EDEMA		Approximate Interval Between Onset and Death 24 HRS
8760,	ate be executed hysician and the burial-transit	dical Examiner	Sequentially fist conditions, if any, hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. The THY Cause Country that initiated events resulting in death) Last c. Due to (or as a consequence of the country that initiated events resulting in death) Last		CE K	
P.O. Box 68	ii the death certificate I by the attending physi iached for use as the I	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yo 9 ☐ Unknown 23c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
	es tha igned be de	by P	Part II. Other significant conditions contributing to death but not resulting. ASTHM A	ng in the underlying cause given in Part I.		co use contribute to the cause of death?
Division of Vital Records,	The law requir ate has been si page 2 should	Completed	HYPERTENSION		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ 10
tal		a	25. Was case referred to medical	26. Place of Deat	h (Check only one)	
>	ysici is cer direc	0 B	examiner? 1 Yes 2 No Hospital: 1 npatient 2 EF	VOutpatient 3 DOA Other: 4 Nursing Ho	me 5 Residenc	e 6 Other (Specify)
0	ng Ph ter th	n: T	(Month Class Vees)		28d. Describe how	
ion	# 2 X 2	atio	1 Matural 5 Pending (Month, Day rear) 2 Accident investigation	M 1 Yes 2 No		
Divis	al or Attendi after death I Director: A d in by the f	Certification:	3 Suicide 6 Could not be determined 28e. Place of fnjury - At hombuilding, etc. (Specify)	e, farm, street, factory, office	28f. Location (Stree City or Town, S	at and Number or Rural Route Number, State)
	To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.			
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	29d	Date signed (Month, Day, Year)
	, ,		- when &	RES COO		6-5-04
-	6		30. Name and address of person who completed cause of death (Item 2	3a) (Type, Print)		
	9		ZEEBA MATHEWS, 5601, L	OCH RAVEN BLUD,	BALTIM	DRE MD-21239
T	St Regist	ate rar	31. Date fifed (Month, Day, Year) JUN 0 9 2004 32. Registrar's Signatur			

DHMH 17 Rev 1/2001

AUSTIN HOBREY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Lillian 3:00 PM Brink June 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Randallstown Northwest Hospital Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec 18 1931 9. Birthplace (State or Foreign Country)
Ohio 5. Social Security Number 7. Age (In yrs. last birthday) 1□ M 2√ F 72 Yrs. 280-26-8889 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Marriottsville MdCarroll 1 ☐ Yes 2 ☐XNo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21104 USA 6913 Ridge Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ NO If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) businesswoman food service 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Harvey Madison Lena Preston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Memmert (daughter) 6903 Pine Hill Ct., Marriottsville, Md 21104 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial 6-11-04 Sykesville, Md 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Parge Hargert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) neumonia weeks Due to (or as a consequence of) Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 X Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Npatient 1 ☐ Yes 2 No 3□ DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending Injury Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined

The law requires that the death certificate be executed attending physician Physician/Medicai jo detached ģ 99 page 2 should Completed certificate has Physicien: Be

burial-transit use as the director his funeral c After

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

2

Examiner

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, Its Modified Exporter must be notilized at

permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Montal Hygiene. Important: If Item 27 is marked other than "natural", or Items 27 any injury or other traumatic.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

O. Box 68760.

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Division of Vital Records,

or Attending

the Maryland

Certification: To within 24 hours after death.

To the Funerel Director: A completely filled in by the fu To the Hospitel Medicai

State Registrar

William Tan 31. Date filed (Month, Day, Year)

3 ☐ Suicide

4 Homicide

(Check only one) 29b. Signature and till of



1645

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Ruad

29c. License number

D34849

Eldersbur

28f. Location (Street and Number or Rural Route Number, City or Town, State)

June

MD

29d. Date signed (Month, Day, Year)

2004

ORIGINAL

Liberty

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Vear BROWN **Physician** PM CLANA 1:50 2004 /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner unde eath surnie Mariner Date of Birth (Month, Day, If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1**XX**M 2□ F Hours Min. TAMPA, FLORIDA 12/29/1905 214-22-7270 98 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show r than "natural", or Items 23a or 28a-f shov the Medical Examinar must be notified at 1 ☐ Yes 2 XXIo LINTHICUM MD ANNE ARUNDEL Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 21090 USA 316 DARLENE AVENUE Funeral death permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene Important: If Item 27 is marked other than "natural" any injury or other traumatic average. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 2 3XXWidowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be UNKNOWN JOSEPH PHILLIPS ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 316 DARLENE AVENUE, LINTHICUM, MARYLAND 21090 MELBA DVORSAK - DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State BALTIMORE, MD ' 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 6/8/2004 21. Signature of Funer Statice Licensee 22. Name and Address of Facility FINK FUNERAL HOME, PA KELLY CRECORY INK 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 #M01148 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fature. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AWTE Physician HOU /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Day Year 5 Cher (specify) 4 ☐ Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, should be 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy performed/ 1 ☐ Yes 2 No Division of Vital To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 SNo 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No м 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14.0

32. Registrar's Signature

RGOGE

(Month, Day, Year) 7 9 2004 0-22609

FURNACE BRANCH POR GLEN BURNIE MED 21060

			1- State of Maryland / Department of Certificate of		ental Hygiei Reg.	2001 10116
I	Physic		Decedent's Name (First, Middle, Last) Anna J. Cronin			Day Year 3. Time of Death 3:10pm M
	/Medi Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Tow	n, or Location of Death		4c. County of Death
				n Burnie ear If Under 24 Hrs.		Anne Arundel
	Funeral Director			ays Hours Min.	8. Date of Birth (Month, Day, Ye April 9,	9. Birthplace (State or Foreign Country) 1916 MD
0.	ס		Usual Residence of Decedent		iipiii 57	
	e Maryla a-f ahov lifted at	ctor	10a. State 10b. County N/A 10c. City, Town or Location		Baltimo:	re City 10d. Inside City Limits
	h with th	Funeral Director	10e. Street and Number 1445 Richardson St.	^{de} 21230		Citizen of What Country? USA
36	be filed within 72 hours after death with the Maryland tial Hygiena dother than *natural', or Itams 23a or 28a-f ahow avant, the Modical Executive cost to rutified and avant, the Modical Executive cost to rutified and the continuous costs.	by Funer	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes, Give Sear O'Dates:	of Hispanic Origin? (Spe Cuban, Mexican, Puerto I No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	in 72 hou n *natura	Completed l	15. Decedent's Education 16a. Decedent's Usual Oc (Specify only highest grade completed) (Give kind of work of life, DO NOT use re	one during most of working	16b	. Kind of Business/Industry
212	giena. giena. ar than	Som	Elementary/Secondary (0-12) College (1-4or 5+) Factor 8 Factor	ry Worker		Manufacturing
	buld be filed Mental Hygid arkad othar atic avant, II	To Be (17. Father's Name (First, Middle, Last) George Leighling	18. Mother's Name Julia H	(First, Middle, Maid eim	
Maryland	2 she and is m	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Str			y or Town, State, Zip Code)
a,	a 0		20a. Method of Disposition 20b. Place of Disposition (Name or cemetery, crematory or other	f place)		MD 21619 Location - City or Town, State
Ē.	Pa In I	10	'4 Donation 5 Other (Specify) HOLY Cross Cem.		2004 E	Baltimore Maryland
Bal	permit. Departr Importu any inji		21. Signature (Funera Servictor Doda, Jr. 22. Name and Ac Charle 1501	S L. Steven	s Funeral	Home, Inc. 1timore MD 21230
	Physician /Medical Examiner	ıer	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A12 HEIMER DISTRIPTION DISTRIPTION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying.	SEASE	respiratory arrest,	Approximate Interval Between Onset and Death
	icate be executed physician and s the burial-transit	dical Examin	Cause (Disease or Injury that initiated events resulting in death) Last C			
.O. Box (The law requires that the death certific te has been signed by the attending r age 2 should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant 4 Pregnant at time of death 5 Other (specify of the pregnant) 1 1 1 1 1 1 1 1 1			23d. Date of delivery Month Day Year
rds, P	quires that n signed k ıld be dett	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause PERIPHERAL VASCULAR DISEASE		23e. Did tobacc	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
		Completed	GANGRENE OF THE FEET		24a. Was an autopsy performed?	
N N	Physician: T this certificat ral director, pa	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	26. Place of Death Other:		0 Flore 10 - 10 -
		1-	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 1 Natural 1 Natu	4 M Nursing Hom	8d. Describe how in	6 ☐Other (Specify) jury occurred
Division	Hospital or Attending 24 hours after death. Funaral Diractor: After tely filled in by the fune	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offi building, etc. (Specify)		8f. Location (Street City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the saminary one the samination and/or investigation, in many one)	e time, date and place, are ny opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
ł	To th within To th	Me	29b. Signature and title of certifier 29c. Lice	ense number) 17753	29d. C	Date signed (Month, Day, Year) 6/9/2004 -
	13		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		ST. RA	LTIMORE, MD 21225
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	- i Micali	-, -,	-1, 101-, WID 2122S

			1 - For State Registrar	State of Ma	aryland /	-	ment c			ınd M		giene Reg. No	20	04	18	14
	Physici /Medic		1. Decedent's Name (First, Middle, La Charlotte Le								2. Date of De Month June	Da	y Ye 2004	аг	3. Time of 2:00	
	Examin		4a. Facility Name (If not institution, given 1704 Shirley			4t	b. City, Tov Jop		ocation of	f Death		4c	County of t			
I	Funeral Director		230-30-4818	1 □ M 2 5 F	e (In yrs. last t 74		f Under 1 Y Ionths Da	ear ays	If Under 2 Hours	Min.	8. Date of Bir (Month, Da Aug. 1	v. Year)			ce (State or r) inia	r Foreign
	aryland show	7	Usual Residence of Decedent 10a. State 10b. County Md. Harfor	· d	10c. City, To	own or Location					<u>.</u>			10d	I. Inside Cit	
	or 28a-f	irecto	10e. Street and Number				oppa 10f. Zip Co		1005				izen of Wha		/?	
	death wi	Funeral Director	1704 Shirley Aver	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was	s Decedent		1085	in? (Spe	cify Yes or No Rican, etc.)		nited	American	Indian,	
2-0036	ours after ral', or Ite	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 1 If Yes, Give Year or Dates:	No		Yes 2		Specify:	, Pueno i	Hican, etc.)		Specify:	Vhite, etc whit		
7-012	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. Ite Marified Example and Item India any injury or other traumatic event. Ite Marified Example and Item India and ODGE.	Completed	15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12)			life. DO	d of work de NOT use re	one du etired)	on ring most	of workir	ng	16b. K	ind of Busin		stry	
yland 21	be filed w tal Hygier d other tl	Be Col	8 years 17. Father's Name (First, Middle, Last)		homer	maker		8. Mother	's Name	(First, Middle,	Maiden	OWN h	ome		
Z	should be f and Mental P s markad of umatic eva	2	George Blevins 19a. Informant's Name/Relationship (Type, Print)	19	9b Mailing A	Address (St.	reet an			es Smit		r Town Sta	te Zin Co	nde)	
, Mai	and 2 shalth ar		Margaret Combes/	- ·		1704	Shir	1ey	Aver		Joppa,				506/	
Jore	ages 1 t of He : If itan or oth		20a. Method of Disposition 1 Burial 2 Cremation 3			of Dispositio					ate		ocation - City			
Бант	permit. Pa Departme Important any injury		4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice		High	22. Na	ame and A	ddress	of Facility	,	10/2004 Home o					
	o o ⊨ a o		23a. Part1. Enter the disease, or com	plications that caused	the death. Do									· 21	014 pproximate	
	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. COh	a consequence	UNICE	R							l In	iterval Betwinset and D	
	Examiner	Jer	Sequentially list conditions, if any, leading to immediate cauca. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence	e of):								-		,
,007	ate be executed hysician and the burial-transit	icai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequence	e of):										
O. BOX 0	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Director: Attent this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknowh	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal deal		opic pregna her (specif)						23d. Date of Month	delivery Da	ıy Ye	ear
cords, r.	quires that to signed by all be detact	by	Part II. Other significant conditions of	contributing to death b	ut not resulting	in the under	rlying cause	e given	in Part I.				se contribut			
מו שבכס	i: The law re- icate has bee r, page 2 sho	Completed								_			24b. Were prior death	to compl 1?	findings averaged in the first filter from the filter filter from the filter filter from the f	vailable use of
7	ysiciar is certif directo	o Be	25. Was case referred to medical examiner? 1 Tyes 2 2 30	Hospital: 1 ☐ Inpatie	nt 2□ER/C	Outpatient 3	3□ DOA				(Check only o		S∏Other /S	inecify)		
	inding Ph ath. r: After th ie funeral	ertification; T	27. Manner of Death 1⊅ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injui (Month, Day	Year) 28b.	. Time of Injury	28c. l	Injury a Work?	t s 2 □ N	2	Bd. Describe h			,,		
	tal or Attars after de al Directo	Certific	3 Suicide 6 Could not b 4 Homicide determined		ury · At home, i c. (Specify)	farm, street,	factory, off	ice		28	Bf. Location (S City or Tow	itreet and n, State,	d Number oi)	Rural Ri	oute Numb	Θ <i>r</i> ,
	Hospi 24 hour Funar stely fill	edical	29a. Certifier 1 Certifying Pt (Check only one)	nysician: To the best of miner: On the basis of and manner sta	examination a	ge, death occ und/or investi	curred at th igation, in n	ne time, ny opin	date and ion, death	place, ai occurre	nd due to the o	ause(s) date and	and manner place, and o	as state	d. e cause(s)	
	To the within To the Comple	Me	29b. Signature and title of celtifier	w	(A)		29c. Lic	ense r	11/2				e signed (Ma	onth, Day		
	C		30. Name and address of person who			(Type, Print	it)		íF.	OKIA	THU	9-	m/	0	· /	
	Sta Registr	_	31. Date filed (Month, Day, Year)		ar's Signature	Ann.			*		VIIV					

			For	State of M	faryland / [d Ment	al Hygi	ene ₂	nnı.	10110
		1	State Registrar			Certificate	of De	eath			g. No.	004	1014-8
	Physicia	an	1. Decedent's Name (First, Middle,		CRIM	1			- N	ate of Death Ionth	Day 07	Year 2004	3. Time of Death 46AM
	/Medic Examin		4a. Facility Name (If not institution,		r)	4b. City,	Town, or Lo	ocation of D	eath		4c. Cou	unty of Deeth	
	LAGIIIII	Ŭ.	BON SEC	OURS	HOSPITI		ALTIM(NA	
	Funeral Director		5. Social Security Number 214-58-5472	6. Sex 7. A 1X M 2 ☐ F	nge (In yrs. last bir 53	thday) If Under Months Yrs.		Hours N	Vin. (A	ate of Birth Month, Day, V. 13,	Yeer) , 195	Coun	lace (State or Foreign try) SC
7			Usual Residence of Decedent									1	Od. Inside City Limits
.0036 bours after death with the Maryland	r 28a-f show	_	10a. State 10b. County		10c. City, Town		_					'	1 X Yes 2 □ No
N e	Ba-f.	Director	MD	NA		BALT IMOI				10	a Citizen	of What Cour	ntry?
di di	or 2 De D		10e. Street and Number		•	701. Zip		1000		1.0	g. Onizon		, .
aath y	s 23a or nust be	era	11.2 N. SMALLV	12. Was Deceder		13. Was Deced		1223 anic Origin'	? (Specify `	Yes or No-		USA Race - Americ	
<u> </u>	indi.	Funeral	1 ☐ Never Married 2 📆 Marri	Armed Forces ed 1 ☐ Yes 2 ☐	s?				uerto Ricar	n, etc.)		Black, White, AFRI	etc. CAN
036	0,1	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	:	1 ☐ Yes	ZLALNO .	Specify:			Spi	AMEF	RICAN
21215-003	na fur	Completed	15. Decedent (Specify only highes		16a.	Decedent's Usua (Give kind of wo	rk done dur	on ring most of	working	1	6b. Kind o	of Business/Inc	dustry
.1215-	. u .	mpie	Elementary/Secondary (0-12)	College (1-4o	r 5+)	`life. DO NOT us		O DED	A TO D		,	ABOD	
	lygier her t	S	11th 17. Father's Name (First, Middle, I	(ast)		FORK		OPERA 8. Mother's		st, Middle, N		LABOR name)	
and	e eve	9 Be		RIM					ANI	NABELL	E CI	RIM	
Maryland	and Mental Hygiene is marked other than "naturel", or Items aumatic event, the Medical Examinating	၉	19a. Informant's Name/Relationsh		196	. Mailing Address	(Street and	d Number o	r Rural Rol	ıte Number,	City or To	wn, State, Zip	Code)
, Ma	perilli. Popartment of Health and Meniming partment of Health and Meniming 27 is marke any injury or other traumatic socs.		JACKIE J. CRIN	(WIFE)	13	12 N. SM	ALLWO	OD S	TREET			E, MD	
ē,	othe		20a. Method of Disposition	2 Demoval from Stor	cemete	f Disposition (Narry, crematory or o	ne of ther place)		Date	2	Oc. Locati	on - City or To	own, State
E S	nent of ant: If it		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)			EMORIAL	PARK	6/	12/04	I	RANDA	LLSTOW	, MD
Baltimore,	Departm Departm Importe any inju		21. Signature of Funeral School	Liceogee		22. Name ar						HOME PA	1
—	20 5 5 8		ff mym/	11/4/1	5	638 N.						, MD 2	21217 Approximate
			23a. Part1. Enter the disease, or shock, or heart failure. List	only one pause on each	n iine.				rdiac or res	piratory arre	151,		Interval Between Onset and Death
	nysician		Immediate Cause (Final disease or condition resulting in death)	a	num		2EM	ENS					
	/Medical		resulting in death)	Due to (or a	as a consequence	of):							
		-io	Sequentially list conditions, if any, leading to immediate	b. Due to (or .	as a consequence	of):						-	
7	ansit	Examiner	Cause (Disease or injury that initiated events									1	
o	physician and the burial-transit	Exa	resulting in death) Last	Due to (or	as a consequence	of):							
3760,	nysicia nysicia	Cai		d									
89	ing ph	Med	IF FEMALE:								1		
Вох	e attending pt	ian/	23b. Was decedent pregnant in the past 12 months?		ne or pregnancy 2 ☐ Fetel death at time of death	n 3 ⊟Ectopic p 5 ⊟ Other (sa					230	. Date of delive Month	Day Year
P.O.	the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknowr		J⊟ Ottrer (a)	, solify						
	law requires that the de as been signed by the a 2 should be detached f		Part II. Other significant condition	ons contributing to death	h but not resulting	in the underlying o	ause given	in Part I.		23e. Did tob	acco use	contribute to t	he cause of death?
ds	quires than signed land be det	d by							_	1 ☐ Ye	s 2 12 N	lo 3 ☐ Prot	eabiy 4 🗆 Unknown
Records,	aw requir as been si 2 should I	Completed								24a. Was ar autops	v	prior to co	ppsy findings available impletion of cause of
œ,	Ine lav ate has page 2	E								perform 1 ∐ Yes 2	ned? No	death? 1 ☐ Yes	
ita		BeC	25. Was case referred to medica examiner?						f Death (Ch	eck only on	θ)		
> >	Physician: this certific ral director,	P	1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inp		utpatient 3 D		4 LI INUISI	-	5 Reside		Other (Special	(v)
u .		on:	27. Manner of Death 1 ☑Natural 5 ☐ Pendir	ig .	Day Yeer)	Time of Injury M	28c. Injury a Work? 1 □ Ye	at es 2 ∐ No		Describe no	injuly o	ocurred	
isio	Attending ir death. ector: Aftei by the fune	icat	2 Accident investi	not be as Blace of	Injury - At home, f				28f.			lumber or Rura	al Route Number,
É		Certification;	4 ☐ Homicide determ	building,	etc. (Specify)		,			City or Town	i, State)		
_	To the Hospital of within 24 hours at To the Funeral D completely filled in	edicai C	(Check only 2 Medical	ng Physicien: To the be Examiner: On the basi	s of examination a	ge, death occurred nd/or investigation	at the time	, date and p nion, death	place, and o	due to the ca t the time, da	use(s) an ate and pla	d manner as s ace, and due t	stated. o the cause(s)
	thin 24 thin 24 the F	Med	one) 29b. Signature and title of certifie	and manner	sialed.	29	c. License	number		2	9d. Date s	igned (Month,	Day, Year)
1	o T ¥i€) TSma	ii - mal			D3	027	17 -		JUN	E 07	2-004
	1		30. Name and address of person	who completed cause	of death (Item 23a)	(Type, Print)		- 1	-			-	2004
	11		THOMAS S.	MILLER		SECON	725	HOSF	2/11/2	B	ALTI	more	mo.
	St	ate	31. Date filed (Month, Day, Year,	32. Reg	istrar's Signature	,							
	Regist	trar	JUN 0 9 20	04 Sente	me B	Span	6/						

68760,	
Box	
P.O.	
Records,	
ital	

980	be filed within 72 hours after deat atal Hygiene. of other than "natural", or Itams; avent, Ire Model Examiner.	by Funer	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.: Armed Forces? 1	S. 13. Was Decedent of Fif Yes, specify Cub	dispanic Origin? (Specify Yes an, Mexican, Puerto Rican, etc Specify:	or No- Black, Wh Specify:	erican Indian,
21215-0036	within 72 ho ene. than "natur ne Madical I	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of working	16b. Kind of Busines	
d 21	e filed withir Il Hygiene. other than vant, Ire M	Be Com	12th grade 17. Father's Name (First, Middle, Last	na	Care Pro	vider 18. Mother's Name (First, M	Self Emp	loyed
Maryland		To B	Daniel Adamson			Annie Rose	bough	
Man	and and is m		19a. Informant's Name/Relationship (Туре, Print)	19b. Mailing Address (Street	and Number or Rural Route N	lumber, City or Town, State,	Zip Code)
	s 1 and 3 if Health item 27 other tra		Nathan Canty-S 20a. Method of Disposition		4905 Nelson lace of Disposition (Name of	Ave. Balti	more Md 2]	215
Baltimore,	permit. Pages Department of I Important: If ite any Injury or of		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State (V) (Ki	emetery, crematory or other pla ng Memorial	Park 6/9/04		
Bal	permit Depar Impor any In		21. Signary Funeral Service Lice	llruh	March F/ 4300 Wab	H West ash Ave, Ba	ltimore Md	21215
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	rachnoid H	ema orhuye	ory arrest,	Approximate Interval Between Onset and Death
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Uncontro Due to (or as a consequ	11ed Hypertens	ion		
68760,	The law requires that the death certificate be executed tto has been signed by the attending physician and bage Z should be detached for use as the burial-transit	lical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	ience of):			
.O. Box		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 Ectopic pregnance	,	23d. Date of de Month	blivery Day Year
Q .	quires that in signed b uld be deta	ed by PI	Part II. Other significant conditions (Did tobacco use contribute of the contribute of				
Vital Records,		Completed by					performed? _ death?	utopsy findings available completion of cause of s 2 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	EB/Outpetion 3D DOA Oth	26. Place of Death (Check o	only one)	
sion of	ng Pt fter th	tion; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury Wor	v at 28d. Desc	Residence 6 Other (Spanished how injury occurred	ecify)
Division	or Attanding after death. Director: Aftel in by the fune	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	De Blace of Injury At he	me, farm, street, factory, office	28f. Locat	ion (Street and Number or F or Town, State)	lural Route Number,
	To the Hospital or Attandi within 24 hours after death. To tha Funeral Director: A completely filled in by the fu	edical Co	29a. Certifier 1 Certifying Pr (Check only one) 2 Medical Exam	nysician: To the best of my know miner: On the basis of examinat and manner stated.	wledge, death occurred at the tir ion and/or investigation, in my c	πe, date and place, and due to pinion, death occurred at the t	o the cause(s) and manner a time, date and place, and du	s stated. e to the cause(s)
	To the within Fo the complex	Me	29b. Signature and title of certifier		29c. Licens	e number	29d. Date signed (Mon	th, Day, Year)
	M		Charles 10	Diffiel D.		000	June -	1 2004
)			iffith D.O	SiNAI HOS	Piral of Bu	ltimore	
	Sta Registr	ar	JUN 0 9 2004	32. Registrar's Signat	Sparks			
DH	MH 17 Rev 1/2	001						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Months Days

10f. Zip Code

Yrs.

10c. City, Town or Location

Baltimore

Canty

4b. City, Town, or Location of Death

21215

| Sultinuise City | If Under 1 Year | If Under 24 Hrs. | B. Date of Birth (Month, Day, Year) | Min. | Month, Day, Year)

Reg. No. 2001

47

2004

4c. County of Death

10g. Citizen of What Country?

U.S.A.

4:15 P. M.

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 □ No

SC

Day

2. Date of Death

25

Month

June

05

1- State Registreend Item 23b, per DR, G832, 6/9 De rijticate of Death

of

1 □ M **¾**□ F

Elizabeth

Bultimore 7. Age (In yrs. last birthday)

57

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

10b. County

NA

HOSPITAL

6. Sex

Barbara

SINAI

10a, State

MD

5. Social Security Number

10e. Street and Number

4905 Nelson Ave

250-86-8561 Usual Residence of Decedent

Physician

Examiner

Funeral

Director

r Itams 23a or 28a-f shov drer - ust be notified at

Director

the Maryland

with

/Medical

		•	1 - State Registrar	ate of Mary		artment of H			giene Reg. No.2 0 0 L	18150
	a Dhuaisi		Decedent's Name (First, Middle, Last)	-				2. Date of Dea		3. Time of Death
	Physici /Medio		Ellsworth, Dettu	ne1				June	04 200	1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 /
	Examin	ier	4a. Facility Name (If not institution, give stree		40.4	0 115	Location of Death		4c. County of De	eath
			5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8 Date of Birt	h las	inthplace (State or Foreign
	Funeral Director		220-14-4984 X		Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day May 27	1924 M	Country)
			Usual Residence of Decedent							
	show	7	Md Carroll		c. City, Town or Lo ${\sf Sykesvil}$					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	Director	10e. Street and Number		Dynesvii	10f. Zip Code			10g. Citizen of What	
	filed within 72 hours after death with the Maryland Hygiana. other than "natural", or Items 23a or 28e-f show ont, I've Medical Evar, it all must be rediffed at	ä	6807 Autumn View Dri	ve		21784			USA	Country
	death	Funeral	11. Marital Status 12. V	Vas Decedent Ever		Was Decedent of Hi	spanic Origin? (Spe	ecify Yes or No-	14. Race - Ar	merican Indian,
9	after des or Items	Ē	1 Never Married 2 Married	med Forces? ▼Yes 2 □ No Yes, Give	WWII	If Yes, specify Cuba 1 ☐ Yes 2√☐ No	Specify:	Hican, etc.)	Black, W	·
003	ural',	d by	JE Wildowed 4 Bivolod	ear or Dates:		21			Specify: W	
15-	"nate	Completed	15. Decedent's Education (Specify only highest grade continuous)	npleted)	16a. Dece (Give	dent's Usual Occupa kind of work done o DO NOT use retired	ation <i>furing most of worki</i> 1	ng	16b. Kind of Busines	ss/Industry
12	filed withi Hygiene. other than	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		body repa			automoti	ve
٦	e filec al Hyg other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,	Maiden Surname)	
Vlar	should be and Mental s marked c umatic ave	70 E	George Leonard Dett	ner			Florenc	e A. Sc	hafer	
Maryland 21215-0036	s m s m		19a. Informant's Name/Relationship (Type, I Melinda Roberts (da:			-			r, City or Town, State	
	Health tem 27 l		20a. Method of Disposition					Date	wn, Md 211	
Jor	Pages nent of t int: If ite iry or of		1 XBurial 2 ☐ Cremation 3 ☐ Remo			sition (Name of matory or other place apel Ceme			Marriotts	
Baltimore,	artme ortani injury		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 	9		-1-	Ĩ		eral Home	
Ba	permit. Pages 1 Department of H Important: If iter any injury or oth		Duan L. H.	mg (t	P	.0. Box 1	95 Sykesv	ille, M	ld 21784	
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can distance of the complete shock.	use on each line.	death. Do not ent	er the mode of dying	g, such as cardiac c	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical	ľΝ	Immediate Cause (Final disease or condition resulting in death)	Brain 1	come s					
	Examiner			Due to (or as a co	nsequence of):					
		Je l	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	nsequence of):					1
	cuted nd ransit	Examine	if any, leading to immediate cause. Enter Underlying Cause Uniscension in the Cause Cause or injury that initiated events c							
0	tate be executed thy sician and the burial-transit		resulting in death) Last	Due to (or as a co	nsequence of):					
8760,	death certificate be executed e attending physician and od for use as the burial-transit	dicai	d							
ox 6	eath certific attending p I for use as	Physician/Me	IF FEMALE: 23c.1	yes, outcome of pr	regnancy				204 Date of a	The second secon
Bo	atten for us	cian	in the past 12 months?	Live birth 2 Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	Day Year
o.	at the de by the tached	ysi		Unknown						
S, P	requires that the reen signed by th hould be detache	by P	Part II. Other significant conditions contribu	ting to death but no	ot resulting in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ğ	v require been sig should b							1 🗆 Y	es 2.121No 3⊟:	Probably 4 Unknown
Record	aw as b	Completed						24a. Was a		autopsy findings available completion of cause of
	The ate h page	Con						pertor	med? death′ 2IPNo 1☐Ye	?/
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	tol:		04	26. Place of Death	(Check only or	ne)	_
of	Physical this call dir	2	THE ZIMINO	tal: 1 Inpatient Ba. Date of Injury	2 ER/Outpatier		4 Nuising Ho		ence 6 Other (Sp ow injury occurred	pecify)
		tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ar) Injury	Work	res 2 No	200. Describe II	ow injury occurred	
Division	Attending or death. actor: After by the fune	ifica	a Countries 6 Could not be	Be. Place of Injury - building, etc. (S	At home, farm, str		-		treet and Number or	Rural Route Number,
Ö	o Fred	Certification:	4 Homicide	building, etc. (S	pecify)			City or Tow	n, State)	
	e Hospitel of 24 hours at e Funeral Dietely filled i	edical (29a. Certifier (Check only one) 12 Certifying Physicia 2 Medical Examiner:	n: To the best of my On the basis of exa and manner stated.	y knowledge, deat mination and/or in	h occurred at the tim vestigation, in my op	e, date and place, a pinion, death occurre	and due to the dead at the time, o	ause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier			29c. License	number	2	29d. Date signed (Mo	nth, Day, Year)
	*		Y WAY	M		MD3	4515		June 04,	2004
	10		30. Name and address of person who comple	ted cause of death	(Item 23a) (Type,					- 1 P - 1 P
			Mary Noky 2	2 South	n Green	re St. Ba	1timive	City,	MD 212	01
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 9 2094	32. Registrar's S	Signature	Sparks				

			, ioi	partment of Health and Mertificate of Death	lental Hygie	2001	18151				
	Physic	an	Decedent's Name (First, Middle, Last)	hv	2. Date of Death	Day Year 2004	3. Time of Death				
	/Medi		James O. Eller 4a. Facility Name (if not institution, give street and number) 1520 W. North Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	4b. City, Town, or Location of Death Balto	8 Date of Birth	4c. County of Death	lace (State or Foreign				
	Funeral Director		215-30-5392 1XM 2□F 69 Yrs. Usual Residence of Decedent	Months Days Hours Min.	(Month, Day, Ye 3-27-19	iar) Coun	N.C.				
	e Maryland Ba-f ehow	ctor	10a. State 10b. County 10c. City, Town or limited Md N/A Balto			10	0d. Inside City Limits 1				
	23a or 2	Funeral Director	10e. Street and Number 1520 W. North Avenue	10f. Zip Code 21217		Citizen of What Coun	try?				
980	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. Item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event. The Madical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, s					
21215-0036	within 72 ho iene, rthan *natur ihe Medical	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of work DO NOT use retired)	ing	Kind of Business/Indeneral Mot	•				
Maryland 2	2 should be filled within and Mental Hygiene. Is marked other than aumatic event, Ine Ms	To Be C	17. Father's Name (First, Middle, Last) Unk		e (First, Middle, Maid Clain	den Sumame)					
	Pages 1 and 2 shi tent of Health and int: If item 27 Is m iry or other traum	ĺ	Loretta Ellerby - Wife 20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 □ Removal from State		Balto, Md						
Baltimore,	permit. Pages Department of Important: If it eny injury or once.		Mt Zion Cemetery 6-14-2004 Lansdown, Md 21. Signature of Funeral Service Liceosee Mt Zion Cemetery 6-14-2004 Lansdown, Md								
8760,	Physician and // // // // // // // // // // // // //	dical Examiner		Approximate Interval Between Onset and Death							
.O. Box 68	The law requires that the death certificat ate has been signed by the attending phy age 2 should be detached for use as the	Physician/Medi		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	y Day Year				
<u>α</u>	w requires that the bound by should be detact	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	>	o use contribute to the	e cause of death?				
Vital Records,		Completed	J'hyperlibidemis		24a. Was an autopsy performed 1 Yes	? death?	sy findings available pletion of cause of				
of	ing Physick After this ceri uneral direct	examiner? Comparison Compa									
Division	safer death.safer death.al Director: All Director: All de in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural ate)	Route Number,				
	To the Hospital or Att. within 24 hours after de To the Funeral Direct. completely filled in by the	edical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occurre	ed at the time, date a	and place, and due to	the cause(s)				
į	with Con	×	29b. Signature and title of certifier	29c. License number DSDF &	29d. C	Plate signed (Month, D					
	.,		30. Name and address of person who completed cause of death (Item 23a) (Type A C LLA B LOW D LO W LC 7	REDWOOD STREET	=1 SVITE	1620 15 SL	70 mm				
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Joans							

Physician /Medical Examinar A Facility Name (If not institution, give street and number)			2. Date of Dea			1 00 00
As Freight Man and Man State State State As a second constitution			JUne	Day	Year	3. Time of Death
Stella Maris at Mercy Hospital]	or Location of De Baltimor	e City	4c. County		11 00 1
Director	hday) If Under 1 Year Months Days			,1943	9. Birthpla Count	ace (State or Foreign ry) MD
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town 10c. City, Town	or Location Baltimore	e City			10	od. Inside City Limits
th contract of the street and Number 1352 Andre Street	10f. Zip Code	21230		10g. Citizen of V USA	Vhat Count	
10a. State 10b. County 10c. City, Town 1	13. Was Decedent of I If Yes, specify Cub		Specify Yes or No- into Rican, etc.)	14. Race Blac Specify	- America k, White, e	
The state of the s	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of w	orking	16b. Kind of Bu	siness/Indu	ustry
TO DE STATE OF THE	Sales	1	ame (First, Middle,	Maiden Sumam	uckin	g
Trisha Easton / Daughter 89	Mailing Address (Street	t and Number or I	Margaret			Code
Trisha Easton / Daughter 89	91 North Ke	entucky	St. Arli	ngton V.	A 22	205
20a. Method of Disposition 1 Burial 2 XI Cremation 3 Removal from State 1 Burial 2 XI Cremation 3 Removal from State 1 Donation 5 Other (Specify) 21. Signature of Euneral Service Licensee Victor P. Doda, Jr.	w Crematory or other pla w Crematory		8, 2004	Balti		Maryland
21. Signature of Eunered Service Licensee Victor P. Doda, Jr.	22. Name and Addre Charles L. S 1501 Fast. Fo	tevens Fur	eral Home, Baltimore	Inc. MD 21230		
Physician //Medical Examiner 23a. Part1. Enter the disease, or complications hat caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of a cause, Enter Underlying Cause, Enter Underlying Cause, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of a cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of a cause (Disease or injury that initiated events resulting in death) Last	ot enter the mode of dying the first of the				1	Approximate Interval Between Onset and Death
O d the table of t	3 □Ectopic pregnanc; 5 □ Other (specify) □	y		23d. Date Mon	of delivery	√ Oay Year
O to the state of	the underlying cause giv	ven in Part I.			bute to the	cause of death?
			24a. Was a autops perform	ned? pr	for to comp eath?	sy findings available pletion of cause of
25. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 No 27. Manner of Death 28b. Tir (Month, Day Year) 27. Manner of Death 28c. Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm building, etc. (Specify)	me of 28c. Injury Wor	her: 4 Nursing	eath Check onl on Home 5 Reside 28d. Describe ho	ence 6 Other	d	
The state of the s	death occurred at the tir for investigation, in my c	me, date and plac opinion, death occ	e, and due to the ca curred at the time, d	ause(s) and man	ner as state	red. he cause(s)
et i di d	29c. Licens			9d. Date signed		
30. Name and address of person who completed cause of death (Item 23a) (To Marvin J Feldman	Jo 301 ST	2930 Davi 101	Bald	UNE 1	, 200	1. 71702
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Sports	I NUL P		imore	11 (6	ے، رزدار

			1 - For State Registrar	State of Maryland		t of Health and e of Death		ie io.2004	18153
	Physici /Medic		1. Decedent's Name (First, Middle, Last	ELLENBER			2. Date of Death Month D A 3	ay J 2004	
	Examin Funeral		4a. Facility Name (If not institution, give Howard County 5. Social Security Number 6. Se	General Hos	pital Co	Town, or Location of Deal lumbia 1 Year If Under 24 Hr. Days Hours Min	8. Date of Birth (Month, Day, Yea		place (State or Foreign
	Director Mou		214-54-9868	10c. City	Town or Location		Nov 11 195		10d. Inside City Limits
	with the Ma 3s or 28s-f s	Funeral Director	10e. Street and Number 3575 Sharp Road		10f. Zip	Code 1738	10g. C USA	Citizen of What Cou	1 ☐ Yes 2 🛣 No intry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or items 23a or 28a-f show appring or other traumatic event, the Medical Examinar must be multiped at ances.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates:	13. Was Deced ff Yes, spec	dent of Hispanic Origin? (cify Cuban, Mexican, Pue 2 No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ameri Black, White, Specify: Whi	, etc.
Maryland 21215-0036	d within 72 ho giene. or than "natur the Madical.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		16a. Decedent's Usua (Give kind of wo life. DO NOT us homemal	rk done during most of wo se retired)	orking	Kind of Business/Ir	ndustry
yland	nould be file I Mental Hy narked othe natic event,	To Be C	17. Father's Name (First, Middle, Last) Lloyd Anderson	Original Control		Peggy E			-0.41
	1 and 2 st Health and am 27 is n ther traun		19a. Informant's Name/Relationship (T) Robert L. Ellenbe: 20a. Method of Disposition	rger (spouse)	3575 Shan	(Street and Number or F	wood, Md 21		
Baltimore,	permit. Pages Department of Important: If it any injury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Page Haight →	A11	22. Name an	emation 6-4	-04 Syk	esville, 1 Home &	Md
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, facting to animediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence. Due to (or as a consequence.	Do not enter the mod	Box 195 Syke to of dying, such as cardia	c or respiratory arrest,	21704	Approximate Interval Between Onset and Death
P.O. Box 68760	death certific e attending p id for use as f	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	death 3 Ectopic pr			23d. Date of deliver	ery Day Year
Ś	The law requires that the ste has been signed by the bage 2 should be detache	þ	Part II. Other significant conditions co	ntributing to death but not resu	lting in the underlying ca	ause given in Part I.		o use contribute to to	he cause of death?
of Vital Record		Completed					24a. Was an autopsy performed?	prior to co death?	opsy findings available impletion of cause of 2 No
of Vit	iding Physician: th. : After this certific funeral director,	: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death		ER/Outpatient 3 DC		Home 5 Residence 28d. Describe how inj		(y)
Division	r Attanding ter death. irector: After n by the fune	ertification:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Year) 28e. Place of Injury - At hor building, etc. (Specify,	Injury M me, farm, street, factory	Work? 1 ☐ Yes 2 ☐ No	28f. Location (Street a	and Number or Rura	al Route Number,
۵	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai Cer	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my know iner: On the basis of examinati and manner stated.	vledge, death occurred ion and/or investigation,	at the time, date and plac in my opinion, death occ	e, and due to the cause(urred at the time, date at	s) and manner as s nd place, and due to	tated. the cause(s)
)	To the within To the compl	Me	29b. Signature and title of certifier		290	License number	29d. D	ate signed (Month,	Day, Year)
	10		3 Name and address of person who c	ompleted cause of death (Item B. K. IC. H. T. 32. Registrar's Signal	23a) (Type, Print) How	ard Coun	ty Gen.	Hosp	a.
	Sta Registr	-	31. Date filed (Month, Day, Year)	Je. neglisirai s signat	food f		O		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 6/09/04 IH 6/09/04 IH Registrer AMEND ITEM #1 PER PHY G832 Reg. No. 2004 1. Decedent's Name (First, Middle, Last) 2. Date of Death BURGOYNE FRANK Month **Physician** RANK 0900 AM 1341-40 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Count ownbia toward If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 10 M 20 F Days Yrs. Director 214-24-6276 10 1924 Md Aug Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or itema 23a or 28a-f show empirity or other traumatic event, the Medical Evantral must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Md Howard Director Ellicott City 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11764 Triadelphia Road 21042 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yho If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Westinghouse Corp. College (1-4or 5+) stockroom clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward Rossetter Frank Sr. Edna May Ridgely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Frank (Nephew) 11785 Triadelphia Rd., Ellicott City, Md 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Mt. View Cemetery 6-4-04 Marriottsville, Md 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee tredust trainscapede P.O. Box 195 Sykesville, Md 21/84 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician mulu /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this cardificate has been approximated to the Funeral Director: attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physiclan/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 → No 3 □ Probably 4 □ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has b Irrector, page 2 s 24a. Was an autopsy performed? 1 Yes 2 No After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check onlone Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 1 Inpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

completely

State Registrar

31. Date filed (Month, Day, Year) JUN 0 9 2004

30. Name and address of person who complet

lee

29b. Signature and title of certifier

32. Registrar's Signature

d cause of death (Item 23a) (Type, Print)

29c. License numbe

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			AMEND ITEM #18 PER	State of Maryland FH G832 6/16/						04	1815	5
	Physici	ian	1. Decedent's Name (First, Middle, Last))				2. Date of De	0 636	Year	3. Time of Death	-
	/Medic			FRANK				6	5	64	8:00p	
1	Examir	ner	4a. Facility Name (If not institution, give :			4	lb. City, Town, or I					
			6281 Oakland Mil: 5. Social Security Number 6. Sex		et hirthdayl	If Under 1 Year	Sykesvi		Carr			
	Funeral Director			M 2□ F 77		Months Days	Hours Min.	8. Date of Bir (Month, Da NOV 8	1926	Md Md	ace (State or Foreigny)	дп
	work work		10a. State 10b. County	10c. City,	Town or Loca	tion				10	d. Inside City Limit	s
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	ith the	Sire.	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Counti	y?	
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020	pamit. Pages 1 end 2 should be fliad within 72 hours after death with the Marylend Dapartmant of Health and Mental Hygiena. Important: If Item 27 is marked other than "netural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at ones.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ⊕Yes 2 □ No 194. If Yes, Give Year or Dates: 194.	5- If Y	_	ispanic Origin? (S in, Mexican, Puerti Specify:	pecify Yes or No o Rican, etc.)	Specif	ce-America ck, White, e y: whit	tc.	
5	72 ho	ted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. DO NOT use retired)							usiness/Indu	ıstry	
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D	illad Hygi other	Be	17. Father's Name (First, Middle, Last)		}		18. Mother's Nan	ne (First, Middle,	, Maiden Surnan	ne)		
/lar	uld be Jenta rked rtic ex	To B	James W. Frank				Dora Ca	iley L	TLLTAN (T.AUSS		
lan	2 sho and I Is ma		19a. Informant's Name/Relationship (Ty)				and Number or Ru	ra / Route Numb	er, City or Town,	State, Zip C	Code)	
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Baltimore, Maryland	Pages Inant of Hant of Hant of Hant or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emovar nom State		on (Name of lory or other plac		Date	20c. Location	•		
İţi	artma ortani injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License			Cemete		6-9-04	Union E	Bridge	,_Md	
8 	parmi Dapa Impo any is		▶ Paige Häught	Page Haight Stribert P.O. Box 195 Sykesville, Md 21784								
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. e cause on each line.	Do not enter t	the mode of dyin	g, such as cardiac	or respiratory a	rrest,	1	Approximate nterval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final	4	1 3	leuke	2 0				MSet and Dean	
	Examiner		disease or condition resulting in death) a		as a conseque		m , c				11.87	
	D #	ner	₩.	200 to (5. 2	as a conseque.	nce or _j .				1		
,	Physician: The law requires thet the daath certificata ba executed this certificate has been signed by the attanding physician end aral director, page 2 should be dateched for use es the buriel-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	άδ α συποσημεί	nce of).		,				
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89 x	artifica ling ph	Med	resulting in death) Last	·	,							
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o.	the da	ysk	Part II. Other significant conditions cont			rlying cause give	en in Part I.				he cause of death	
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Division of Vital Records,	v requires been sig should b	Completed b						24a. Was	an autopsy med?	avail	autopsy findings able prior to pletion of cause eath?	
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<u> </u>	ysicia s cert direct	To B	eveminer?	ospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatient	3□ DOA Othe	26. Place of Deat or: 4□ Nursing Ho		<i>ne)</i> dence 6 ⊡Othe	ar (Specify)		
0	ng Phy ter thi neral	ä	27. Manner of Death 1 Natural 5 □ Pending		8b. Time of Injury	28c. Injury Work			now injury occurr			
Sio	eath. or: Af the fu	cath	2 Accident investigation 3 Suicide 6 Could not be				res 2□No					
Ž	To the Hospital or Attending Physician: The law within 24 hours after death. To tha Funarel Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, fam, street,	factory, office		28f. Location (S City or Tow	Street and Numb m, State)	er or Rural F	ło <i>ute Number</i> ,	
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	o the vithin	₹ E	29b. Signature and title of certifier	and mainer stated.		29c. License	number		29d. Date signed	d (Month, Da	y, Year)	
	->-	İ	I found of	mont, M.D		Md	# 0/	2225	61	18104		
•	6		30. Name and address of person who con	malatad and a design (tem 0)	· 3a) (Type, Prir	nt)						
				+2, M.D. 55	55 S.	CR47	HRL St	L. W.	estania.	1+ 45	md 211.	57
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unpend item#23a,27,28a-f,PER ME,G832,6/24/04eg Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Alexander David Fields 04-03766 State of Maryland / Department of Health and Mental Hygiene MAN 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2004 Month **Physician** June 05, Alexander David Fields 2148 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 104 Lionshead Court Baltimore Rosedale If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1**∑**M 2□F 46 Director 218-72-8461 YES June 28.1957 Massachusetts Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examiner may be notified at 1 ☐ Yes 2 🛛 No Director Maryland Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 Lionshead Court 21237 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: tams ; Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural', or 1 ☐ Yes 2 X No Specify: White þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If itam 27 la markad other than "na any injury or other traumatic event, Ita Medic once. Self-Employed Elementary/Secondary (0-12) 12th Grade Colfege (1-4or 5+) Painter Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lila Jerru Fields Feitelberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 Northford Way, Baltimore, MD 21234 Mrs. Peggy E. Torr (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 6/10/2004 Baltimore, Maryland Bayview Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Narcotic Intoxication Pnysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ysician and e burial-transit To the Hospital or Attanding Phyaiclan: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Dav 5 Other (specify) 4☐Pregnant at time of death signed by the a 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 No 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6XIOther (Specify) 1XYes 2□No 2 At scene After thi funeral 28a. Date of fnjury **found**onth, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 - Natural 5 Pending investigation death. 6/5/04 unknown 1 ☐ Yes 2 ▼No unknown 2 Accident Diractor 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

found at home filled in by 4 - Homicide 104 Lionshed Ct., Rosedale, MD within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. June 06, 2004 Monte, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARGONTO DRELL 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 0 9 2004

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		Registrar			enilicate of	Deam	2. Date of De	Reg. No.	L 0 0 -	3. Time of Death
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rs aft	by F	t ☐ Never Married 2XXXMarried 3 ☐ Widowed 4 ☐ Divorced	1XXves 2□No If Yes, Give Year or Dates: Kore	a	1 □ Yes 2🖎 No	Specify:			Specify: W	hite
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	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle	Maiden	Sumame)	
	10	Charles J. Facey					ny S. Ha			
Marylis d 2 should th and Mer it is marke traumatic		19a. Informant's Name/Relationship (1	Mailing Address (Stree				Town, State, Z.	ip Code)
C = 64 F		Marjorie A. Face		_	Box 35,		n, MD 20 Date		cation - City or 1	Fown State
n		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	I Hamovai from State		Disposition (Name of crematory or other pla	1				
Baltimo permit. Pego Department Important: It sny injury o		*4 □ Donation 5 □ Other (Specif		urre	ction Ceme	-	2004	Cli	nton, M)
Dail permit. Depart Import sny inj		21. Signature of Funeral Service Licer	1500		22. Name and Addr Hardesty	Funeral	Home, P	.A.	03	. 7.3
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat	h Dono	12 R1dge	ly Avenue	Annap c or respiratory a	OLIS rrest.	, MD 214	Approximate
Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conseq	S y	STEM	ORGAN	FAI	FLU	RE	Interval Batween Onset and Death 3 LUCKS
/6U, le be executed ysicien and e burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence)):						
GO ifficate g phy as the			(4),111							
Hecords, P.O. Box 687. The law requires that the death certificate in the been signed by the attending physicage 2 should be detached for use as the incoming the states.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnative birth 2 Feta 4 Pregnant at time of continuous 9 Unknown	al death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	су		2	3d. Date of deli Month	very Day Year
that the sed by detac	Ph	Part II. Other significant conditions	contributing to death but not res	sulting in I	he underlying cause g	iven in Part I.	23e. Did 1	obacco u	se contribute to	the cause of death?
d be	d by						1 🗆	Yes 2[□No 3□Pro	obably 4 Dunknown
VITAI HECONDS, P sicien: The law requires that certificate has been signed tr rector, page 2 should be deta	Completed						24a. Was	an	24b. Were au	topsy findings available
The law	m d							rmed)	death?	completion of cause of
		25. Was case referred to medical				26 Place of De	1 ☐ Yes ath (Check only	2 (XNo	1 🗆 Yes	280,140
VITA raician: s certific director,	o Be	examiner?	Hospital: 1 XInpatient 2	ER/Outp	atient 3 DOA	ther	lome 5 ☐ Resi		S □Other (Spec	ofy)
g Phys g Phys er this c	l i	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Tii			28d. Describe			
ION affi. affi. e fun	atio	1 Avatural 5 ☐ Pending 2 ☐ Accident investigation		,		Yes 2□No				
DIVISION Of VITAI To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ome, farr fy)	n, street, factory, office	Э	28f. Location (City or To			ral Route Number,
DIVI a Hospital or At b 24 hours after of Funeral Direct letely filled in by	edical (29a. Certifier 1X Certifying Pl (Check only one) 1 Medical Exa	hysicien: To the best of my knominer: On the basis of examination and manner stated.	owledge, ation and	death occurred at the or investigation, in my	time, date and place opinion, death occi	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
To the within To the comp	M	29b. Signature and title of certifier			_	nse number			e signed (Month	
\sim		Juich.	k-MD		RE	S-000)	JUI	VE. OF	1,2004
19		30. Name and address of person who			ype, Print)		5.4		- ,	D 21202
,		ERICS. WE			B ST. PAL	IL ST.	BALTI	mot	RE, M	D 21202
S Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature 9	boards					

Theresa Feborco

	/M Exa	/sıcı ledic amir
Division of Vital Records, P.O. Box 68760,	ng Physician: The law requires that the death certificate be executed	To the Funeral Director: After this certificate has been signed by the attending physicien and completely filed in by the funeral director pane? Schould be detached for use as the burial transit
Div	To the Hospitel or Attendi	To the Funeral Direc
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			_			nt of Health and	•	•	
			1 - State Registrar		•	te of Death	, ,	3. No. 2004	18158
	Physici		Decedent's Name (First, Middle, Last)	Theresa A.	Fedorco		2. Date of Death Month	Day Year	3. Time of Death 5:44AM
	/Medi Examir		4a, Facility Name (If not institution, give stre			y, Town, or Location of Dea		4c. County of Dea	
		泰	bood Samar	itan Hos	pital 13	altimor	e	NA	
	Funeral Director		220-20-6919	2000 7. Age (In yrs. I	Yrs. If Und Months	ler 1 Year If Under 24 Hrs S Days Hours Min		9. Bird 12, 1924	hplace (State or Foreign untry) Maryland
	death with the Maryland ms 23a or 28a-f show roust be notified at	7.	Usual Residence of Decedent 10a. State 10b. County Maryland	10c. City	y, Town or Location	271+1			10d. Inside City Limits 1 X Yes 2 ☐ No
	ith the Marylar or 28a-f show	Director	10e. Street and Number			Baltimore	100	g. Citizen of What Co	
	h with 23a or	a Di	2105 West	field Ave.		21214		U.S.A.	
036		by Funeral	11. Marital Status 12. 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		edent of Hispanic Origin? (Specify Cuban, Mexican, Puer XX) No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
Maryland 21215-0036	72 hc	Completed	15. Decedent's Educat (Specify only highest grade of	on ompleted) College (1-4or 5+)	16a. Decedent's Us (Give kind of w life, DO NOT	ual Occupation vork done during most of wo use retired)	rking	6b. Kind of Business/	industry
21	ygiene ygiene yer the	Con		5+	Teach			Education	n
and	2 should be filed within of and Mental Hygiene. Is marked other than "raumatic event, the Market	o Be	17. Father's Name (First, Middle, Last) Wi	lliam Wiedefe	e1d		me (First, Middle, Ma 2 Joyal	uiden Sumame)	
aryl	should and Me	10	19a. Informant's Name/Relationship (Type,			ss (Street and Number or Ri		City or Town, State, Z	lip Code)
	and 2 Baith a n 27 is		Francis S.Fedorco, S.		2105Westf	ield Ave. Bal	timore, Ma:	ryland 212	214
Baltimore,	Pages 1 nent of Ho int: If iter		20a. Method of Disposition 2DBurial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	lace of Disposition (N. emetery, crematory or aneyValley	other place)		oc. Location - City or OWSON, Mar	
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	elello-	22. Name a	and Address of Facility Ma	rzullo Fu	neral Chap	el,P.A.
		25 /1	23a. Part1. Enter the disease, or complicate	ions that caused the death			Baltimore or respiratory arrest		Approximate
	Physician	6. 6	shock, or heart failure. List only one of immediate Cause (Final disease or condition	Septis					Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Du- to (or as a consequ	Pneumo	ากาล			7 days
	ed sit	liner	Sequentially list conditions, any leading to mm a allocause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence)	ience of):				7 10 2400
760,	be executed sicien and burial-transit	I Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):	tive Pulmo	wary D		1-10 415
6876	cate b	dical	d						
P.O. Box 6	To the Hospitel or Attanding Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physcompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 Ectopic			23d. Date of deliment	very Day Year
s, P.	es that tigned by	by	Part II. Other significant conditions contrib	uting to death but not resu	ulting in the underlying	cause given in Part I.		cco use contribute to	
ord	v requir been s should	eted	Diabetes	* 1			1 TYes		bably 4 Unknown
Rec	he law e has l age 2 s	Completed	Morbid Obegi	ty			24a. Was an autopsy performed	l prior to c	opsy findings available ompletion of cause of
ita	ilcian: Th certificate rector, pag	0	Hupertension 25. Wis case referred to medical			26. Place of Dea	1 ☐ Yes 2 ☐ th (Check only one)	1 □ Yes	2 No
) \ \	ding Physician: The n. After this certificate ha funeral director, page	To B	examiner? 1 ☐ Yes 2 ☐ No Hosp	1 Impatient 2 L	ER/Outpatient 3□ D	Other	ome 5 Residenc	e 6 □Other (Spec	ify)
ouc	ding P	ion:		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c, Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
Division of Vital Records,	To the Hospile! or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injury - At hor building, etc. (Specify,	me, farm, street, factor		28f. Location (Stree City or Town, S	at and Number or Rui	ral Route Number,
Q	pitel o		29a. Certifier 1 Dertifying Physicis					,	
	te Hos 124 ho se Fundalely (edical	(Check only one)	on the basis of examinati and manner stated.	vledge, death occurred ion and/or investigation	d at the time, date and place n, in my opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the To the comp	ž	29b. Signature and title of certifier			c. License number		Date signed (Month	
		ļ	Millian			Kes 000	J	une 7,	2004
	Q		30. Name and address of person who complete 200 Math	eted cause of death (Item	23a) (Type, Print)	Kes 000 iven Blvd.	Baltim	ore MD	21239
*	Sta	44	31. Date filed (Month, Day, Year)				ter	1 // 12	
	Registr	ar	JUN 0 9 2004	32 Hegistrar's Signati	and !	1			

Physicia		1. Decedent's Name (First, Middle,					2. Date of D	Reg. N	144	ear	3. Time of
/Medica			Helen I	J. Gam	brill		Month 5	20 ^D	200	4"	5:58
xamine		4a. Fecility Name (If not institution, § Angles Alert	give street and number)		4b. City, Town, o	r Location of Deal	th	4	c. County of	Death	
neral ector		212-42-0749	. Sex 7. Age (In yrs 1 ☐ M 2 1 ☐ F 90	s. last birthday Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		irth ay, Year	9.	. Birthpla Country	ce (State o
7		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or L	ocation					100	d. Inside C
	ctor	Md	N/A Ba	altimor	е						1 ∑ Yes
any injury or other troumant event, the market has the state of the st	i Director	10e. Street and Number 711 Brookwood	d Road		10f. Zip Code 21229			10g. C	itizen of Wha	at Country	y?
	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puer	Specify Yes or N rto Rican, etc.)	0-	14. Race -	Americar White, et	
	by F.	1 Never Married 2 Married	1 Tyes 2 TNo If Yes, Give Year or Dates:		1☐ Yes 2☐ No	Specity:			Specify:	Blac	
	Completed by	15. Decedent's (Specify only highest	Education grade completed)	(Give	edent's Usual Occup s kind of work done	during most of wo	orking	16b.	Kind of Busin	ness/Indu	stry
1	mp.	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)	· ·	١.,	Social		
	Be Co	12th grade 17. Father's Name (First, Middle, La	years 2 years			18. Mother's Na	me (First, Middle		minist n Sumame)	trat:	lon
	To B	Raymond L. Wate	rs			Mary H	eln Gri	nne1	1		
		19a. Informant's Name/Relationship	o (Type, Print)		ing Address <i>(Street</i> Brookwood					ate, Zip C	Code)
	1	20a. Method of Disposition		. Place of Disp	osition (Name of ematory or other place	(e)	Date	20c. l	ocation - Cit	y or Tow	n, State
		1 Surial 2 ☐ Cremation 3 1	ocify)	-	thedral C		5-2004	Ва	lto, M	ld	
once.		21. Signature of Funeral Service Lie	censee	2	2. Name and Addre		March F	in the state of		20/20/06/5	
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ian cal		shock, or heart laiure. List or Immediate Cause (Fina disease or condition resulting in death)	a	not	FAlore	Myoca	rdial In	faro	ction		onset and I
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	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse								
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	Physic /Medi Examii	cal	1. Decedent's Name (First, Middle, L HOMAS 4a. Fecility Neme (If not institution, gr The Dhus No.	ve street and number,	G A TAL	BAH	MORE,	City	Day O lo 4c. C	Year 2004	7/4	5 PM
	Funeral Director		220-84-8034 Usual Residence of Decedent	1€ M 2□F 41	Yrs.	Months Day		Irs. 8. Date of Bi (Month, D. Sept.	9, 19	62 Ma	hplece (State ountry) aryland	L
	the Marylar 28a-f show	Director	Pa. York 10e. Street and Number	10	oc. City, Town or Ne	w Park			10- 0			ity Limits 2 [™] No
5-0036	be filed within 72 hours after death with the Maryland nat hygiene. dother than "natural", or items 23e or 28e-f show event, the Mudical Examinat must be notified at	by Funeral	1045 Main Street 11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gi	12. Was Decedent Eve Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:	16a. Dec	1 Yes 2 N	17352 f Hispanic Origin? uban, Mexican, Pu o Specify:	(Specify Yes or Noterto Rican, etc.)	Un 14	ited S Race - Ame Black, White Specify: d of Business/I	tates ncan Indian, a, etc. white	
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	nd 2 sh lith and 27 ls m r traum	-	19a. Informant's Name/Relationship Susan L. Gaumer	/wife	104	5 Main S		Rural Route Numb			ip Code)	
Baltimore,	permit. Pages 1 a Department of Hee Important: If Item any injury or othe once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Cremation 5 Other (Special Control of	Removal from State	Bayview	cosition (Name of ematory or other p	ry 6/8	Date 8 / 2004	Balt	imore,	Md.	
Bal	Depar Impor		21. Signature of Europa Service Lice			610 W.	MacPhail	al Home o Road, Be	1 Air		21014	
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line. a. Due to (or as a co	EUKE		ying, such as care	ac or respiratory a	rrest,		Approximate Interval Bette Onset and I	ween
8760,	death certificate be executed attending physicien and of for use as the burial-transit	dical Examiner	Sequentially list conditions, I any leadong to intraclate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co								
.O. Box 6		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pregnan □ Other (specify)	су		230	d. Date of deliv		'ear
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Ţ	A S D	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie	ent 3 DOA	·	eath (Check only o		Other (Special	fv)	-
Division of	Attending Ph r death. ector: After th by the funeral	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Ye	ar) 28b. Time Injury	W		28d. Describe h			77	
Divi	Dir	l Certiff	4 Homicide determined	building, etc. (S	pecify)			28f. Location (S City or Tox	vn, State)			oer,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only 2 Madicel Examone)	nysician: To the best of miner: On the basis of exa and manner stated.	y knowledge, dea mination and/or i	th occurred at the investigation, in my	time, date and plac opinion, death occ	ce, and due to the c curred at the time, o	cause(s) an date and pla	d manner as s ace, and due to	tated. the cause(s)	
	To the To the Comp	Σ	29b. Signature and title of certifier	Ma			ise number			igned (Month,	Day, Year)	
	10		30. Name and address of person who	Completed cause of death	(Item 23a) (Tunn	D O	05456	59 -	June	6, 2	-004	
			RICHARD SOH 31. Date filed (Month, Day, Year)		FIE 56	8, 600	NORTH W.	OLFE STRE	ET BA	ALTIMOR	ZIZE E MAR	YLAND
20	Sta Registr		JUN 0 9 2004	Se eve	A L	n. V. 1						

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 () () (s 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** June 6 2004 8:20a Gladys Leota /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Continuum Care At Sykesville Sykesvillle Carrol1 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Feb 9 1918 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Deys 1 □ M 2 □ F 217-28-6628 Director Usuel Residence of Decedent pamit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mantal Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumetic event, it a Medical Examinar must be notified at 10d. Inside City Limits 10a. Stete 10c. City, Town or Location Md Sykesville Carroll 1 ∑ Yes 2 □ No Funeral Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 635 Oklahoma Avenue 21784 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give A Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: black Be Completed by 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) domestic homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jerome Taylor Mary Elizabeth Jones 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Peggy Sellers (executor) 89 Blackhead Way, Ft. Myers Beach, FL 33931 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State St. Luke's UMC Cemetery 6-9-04 Sykesville, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee P.O. Box 195 Sykesville, Md 21784 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Physician/Medical Examiner attanding physicien end I for use es the burial-transit To the Hospital or Attending Physician: The law requiras that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. within 24 hours after death.

To the Funeral Director: After this cartificata has been signed by the a completely filled in by the funerel director, page 2 should be datached to 23b. Did tobacco use contribute to the cause of death? Mellita 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 virsing Home 5 Residence 6 Other (Specify) Certification: To 1□ Yes 2☑No 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es steted.

2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical 29c. License number 29d. Date signed (Month, Dey, Yeer) 29b. Signature and title of certifier \mathcal{V}

State Registrar 31. Dete filed (Month, Day, Yeer)

100001

32. Registrer's Signeture

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

JUN 0 9 2004

Les for food

Locales ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Barbara June 8 2004 /Medical 4a Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Kesville Ridge (arrol 5. Social Security Number 6. Sex 1 □ M 2 □ XF If Under 1 Year 8. Date of Birth (Month, Dey, 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country)
 NY **Funeral** Months Days Hours 75 Director 074-22-1149 Yrs. March 22 Usual Residence of Decedent Peges 1 and 2 should be filled within 72 hours efter deeth with the Maryland ment of Health and Mentel Hygiene.

ant: If Item 27 is marked other than "natural", or items 23s or 28s-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md Montgomery Chevy Chase Director 1 ☐ Yes 21 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4615 North Park Ave. Apt 507 20815 USA by Funeral 12. Was Decedent Ever in U,S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 1□ Yes 2□ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) administrative assistant clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Runyan Marion Fave ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0815 4615 North Park Ave. Apt 507, Chevy Chase, Md 19a. Informant's Name/Relationship (Type, Print) Eric Griffel (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of I Important: If Ite any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 6-8-04 Svkesville, Md 21. Signature o Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md21784 23a. Part1. Enter the disease, or complications that cruf ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in death) e. End stage dementia Examiner Completed by Physician/Medical Examiner oneu monia or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last for use es the buriel-trer Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown OSTEOPOROSIS depression 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tes 2140 1 □Yes 2 □ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Norsing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No After this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending within 24 hours efter death.

To the Funeral Director: A completely filled in by the fo 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 032882 part d. M. mo 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) Corter De Restantiona, MI Rabord L. Mais 114 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar FUN OF 2004

DHMH 16 Rev 6/95

GRIFFIN, DEBORAH

ijk.		1 - State Ragistrar				epartment of I Certificate of			Reg. No.	104	1816
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/Medic		DEBIRAN	1)1995	GRIFF	IN			06	05	04	3.068
Examin	er	4a. Facility Name (If not i	-			_	or Location of Death		4c. Cour	nty of Death	
		5. Social Security Number		RITAN H			TIMORE If Under 24 Hrs.		i al-	Na	
ineral rector		110 El 849		M 250F	(In yrs. last birt	rs. Months Days	Hours Min.	8. Date of B	Day, Year)	Cou	place (State or Fore
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			State of Maryland / Dep. 1- State Registrar AMEND ITEM #17&18 PER FH G832e	artment of Health and M 5/17/04 Hillcate of Death		ne No.2004	18161
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	Physic /Medi		FANNIA GIASS		SUNE.	Soul	6.04 P.M.
7	Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
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	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	iar) Cou	place (State or Foreign ntry)
			Usual Residence of Decedent		November 19	19/1/ 19/1	4.
	yland how		10a. State 10b. County 10c. City, Town or Le	ocation			10d. Inside City Limits
	ith the Marylar or 28e-f show	Director	M.D N/a BAIH	more			18 Yes 2 □ No
	라 다 or 28	Dire	10e. Street and Number	10f. Zip Code		Citizen of What Cou	ntry?
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98	within 72 hours after death with the Maryland ene. than "neturel; or liams 23a or 28e-f show the Macical Examiner, ust be political at	y Funerai	1 Never Married 2 Married 1 Yes 2 100	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto f 1 ☐ Yes 2 ☐ No Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	etc.
Maryland 21215-0036	72 hours aft "netural", or	d by	3 ETWIdowed 4 Divorced Year or Dates:			15/0	RCK
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lar	should be nd Mental marked o	To B	UARRES SA.	OBEDIANO	E HAMLET	Γ ε	
ary	and N			ng Address (Street and Number or Rura			Code)
	and and a malth m 27 i		Paggy Horton 5937	Daywart AVE BI		0 21206	
Baltimore,	permit. Pages 1 and Department of Health Important: If itam 27 any injury or other tr 2058.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	natory or other place)	ate 20c	. Location - City or To	own, State
Ë	Pag ment ant:		4 □ Donation 5 □ Other (Specify) Chailenthan	1 Cemetery 6/11	104 3	Homore MI	
3all	permit. I Departm Importar any injur		21. Signature of Funeral Service Licensee	2. Name and Address of Facility BE	HS Funer	al Home	
	40 F # Q			129 N. CAROLINE St		YS MID 21.	213
	Pnysician /Medical Examiner	_	23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Du to (or as e consequence of): Sequentially list conditions,	W .	arest,		Approximate Interval Between Onset and Death 10 includes 2 ecrs
8760,	cate be executed oblysician and the burial-transit	dical Examiner	Sequentially list conditions, if any backing to immodule cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to for as a conjequence of): c. Due to (or as a consequence of): d.				
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rds, F	quires tha in signed l		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobaco	o use contribute to the	ne cause of death? ably 4 □Unknown
Division of Vital Records,	he faw requir s has been s ge 2 should	Completed			24a. Was an autopsy performed	prior to co	psy findings available appletion of cause of
ā			25. Was case referred to medical	26. Place of Death	1 Yes 2 €	No 1 ☐ Yes	2 No
>	ysicia	To Be	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 Ner/Outpatien	Othor		6 ☐Other (Specifi	4)
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Ö	Attending Physician: r death. actor: After this certifics by the funeral director. I	atio	2 Accident investigation	M 1 Yes 2 No			
i×is	or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	8f. Location (Street City or Town, St	and Number or Rura	l Route Number,
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	To the Hospitel or Attent within 24 hours after dealt to the Funeral Diractor: completely filled in by the	edical	29a. Certifier (Check only one) 1 **Certifying Physician: To the best of my knowledge, death of the basis of examination and/or invand manner stated.	n occurred at the time, date and place, an vestigation, in my opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as st and place, and due to	ated. the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month,	
	40-		Mist super Mit	D54502		06-07-	04
_	F		30. Name and address of person who completed cause of death (Item 23a) (Type, Crustal Simpson 550 6 Haplan	Print) rs Baywen Circle	e Baltum	icre Min	21224
	Sta	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature			7	
	Registr	ar	111N 0 9 2004 Com to and	de .			

			1 - For State Registrar	State of Marylan	•	ent of Health and ate of Death		iene 19. No. 2004	18165
	Physici /Medio Examir	cal	Decedent's Name (First, Middle, La. A	H. GR	1/L/O	ty, Town, or Location of De	2. Date of Death	Day Year OH 4c. County of Death	3. Time of Death
	Funeral Director	ier	HOWARD CO 5. Social Security Number 6. S	Gen Hos	pit	CO/UM der 1 Year If Under 24 H	DIA rs. 8. Date of Birth	HOW Year) 9. Birthp	(ALI) Ilace (State or Foreign
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County MD Howard	10c. Cit	ty, Town or Location Columbia		10000 20		0d. Inside City Limits 1 ☐ Yes 2√☐ No
	th with the I 23a or 28a- ist be natif	al Director	10e. Street and Number 5021 Green Mounta	ain Circle		Zip Code 21044	10	Og. Citizen of What Cour United Sta	
5-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show disal Examinet must be notified at	by Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2€ No If Yes, Give Year or Dates:		cedent of Hispanic Origin? pecify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - Americ Black, White,	an Indian,
21215-0	within ane. than "	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	16a. Decedent's U (Give kind of life. DO NOT	work done during most of w use retired)	ronking	Accounting	dustry
Maryland 2	should be filed nd Mental Hygir marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) Anthony Grillo			18. Mother's N Lena	ame (First, Middle, M Calagione	faiden Sumame)	
	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship (John Rossetti/ Co 20a. Method of Disposition	ousin	19b. Mailing Addres 14669	Mustang Path	Glenwood	MD. 21738	
Baltimore,	permit. Pages Department of I Important: If ite eny injury or of		20a. Method of Disposition 1 Burial 2 SCremation 3 4 Donation 5 Other (Specify 21. Sign ture of Funeral Service Licer	Removal from State Met	tro Cremet 22. Name	r other place)	-2004 arry H. Wi	Catonsville Cate's Fami icott City.	e, MD ly FH, Inc
18760,	death certificate be executed Physician and for use as the burial-transit defor use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	h. Do not enter the many process of the control of	ode of dying, such as carding Communications of the communication of the cardinal communication of the cardinal cardina	ancer	Aispaz	Appröximate Interval Between Onset and Death //
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cords, P	v requires been sign should be	by	Part II. Other significant conditions of Part II.	optributing to bath but not resi	ulting in the underlying	g cause given in Part I.		/III	ably 4 Dunknown
Vital Records,		Be Completed	25. Was case reterred to medical examiner?				autopsy perform 1 Yes 2	ed? prior to con death? 1 Yes	osy findings available inpletion of cause of
of	ding Physician:). After this certification of the director, in the direc	on: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Impatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 1 28b. Time of Injury	OOA Other: 4 Nursing 28c. Injury at Work?	Home 5 Residen	nce 6 Other (Specify v injury occurred)
Division	or Attenditer death	Certification:	2 Accident 3 Suicide 4 Homicide		M ome, farm, street, factory)	1 Tes 2 No	28f. Location (Stre City or Town,	eet and Number or Rural State)	Route Number,
	he Hospital in 24 hours al he Funeral D pletely filled i	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 1 ☐ Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death occurre tion and/or investigation	ed at the time, date and place on, in my opinion, death occ	ce, and due to the cau	use(s) and manner as state and place, and due to	ated. the cause(s)
)	To the within 2 To the I complet	Σ	29b. Signature and title of certifier Lacu	ahman,	no 2	1) - 50/8	4	d. Date signed (Month, E	2004
	6		30. Name and address of person who a	ALIKHM	AN 10	3520/di	Annap	polis Rd	, 21042
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture &	for sol			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of M	Maryland / Depa <i>Cei</i>	artment of H rtificate of L			iene •g. No. 2 1 1	L 18166
			Decedent's Name (First, Middle, I	.ast)				2. Date of Deat	th Day Yea	3. Time of Death
	Physicia /Medic		Tae Haeng H	ur				June	4 200	LI PITT M
1	Examin		4a. Facility Name (If not institution, g	ive street and number	r)	4b. City, Town, or	Location of Death	0	4c. County of De	eath
			North Arundel H			Glen Bu			Anne Aru	
	Funeral Director		5. Social Security Number 6. N/A	Sex 7. A	Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan 20	Year) 923 K	hirthplace (State or Foreign Country)
	-		Usual Residence of Decedent						1 - 23	
	ylan how		10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	a-f s	Director	MD ,		Baltimore					XXYes 2 □ No
	ith th	Olre	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?
	238 238	lal	11 W. 20th Str			21218			Korea	
	r dea	Funeral	11. Marital Status	12. Was Deceder Armed Forces	s?	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, W	nerican Indian, hite, etc.
36	s afte , or if	by Fu	1 ☐ Never Married 2 1 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No	1 ☐ Yes ②OX No	Specify:		Specify Ko	rean
8	hour tural		15. Decedent's	Year or Dates		dent's Usual Occupa	ation		16b. Kind of Busine	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Hiter than "natural", or Itams 23a or 28a-f show ant, the Madical Exam ar must be notified at	Completed	(Specify only highest	grade completed)	(Give	kind of work done of DO NOT use retired	during most of worki	ing		
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ğ	Hyg othe	BeC	17. Father's Name (First, Middle, La	st)			18. Mother's Name	(First, Middle, I	Maiden Sumame)	
Maryland	should be and Mental marked o umatic eve	To B	Young Hur				Hyung F	Kim		
ary	2 should have ls main	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street a	and Number or Rura	al Route Number	r, City or Town, State	, Zip Code)
	5 = 2 ±		Yong Gun Hur -	son		x Notches				21228
altimore,	ges 1 at of He		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	☐Removal from Stat	20b. Place of Dispo cemetery, cre	osition (Name of matory or other plac			20c. Location - City	or Town, State
Ĕ	Pag ment tant:		`4 ☐Donation 5 ☐ Other (Spe	city)	Meadowrid		CLIC	/2004	Elkridge	, MD
Ball	permit. Pages 1 a Department of Hea Important: If Item eny Injury or othe		21. Signature of Funeral Service Lie	censee	Ga	2. Name and Address L. Kau 250 Washin	ıfman Fune	eral Hom	e@Meadowr	idge MP, Inc.
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caus	sed the death. Do not en					Approximate Interval Between
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	/Medical		resulting in death)	Due to (or a	as a consequence of):		1	- 1		
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	icate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence of):					
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182	phys phys the	dical		d						
9 x	ding se as	/Me	IF FEMALE:	23c. If yes, outcom	ne of pregnancy				23d. Date of	delivery
Вох	death certifica attending ph d for use as th	ciar	23b. Was decedent pregnant in the past 12 months?			□Ectopic pregnancy □ Other (specify)	·		Month	Day Year
P.O.	that the death ned by the atter detached for u	Physician/Me	1 Yes 2 No 9 Unknown	9 Unknown	1					
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00	s been s been s shoul	olet						24a. Was a		autopsy findings available o completion of cause of
R	sician: The law certificate has b irector, page 2 s	Completed						perform	med? death 2 No 1 ☐ Y	?
Vital	rtifica stor, p	0	25. Was case referred to medical				26. Place of Deatl		-	
/	Physician: this certific ral director,	To B	examiner? 1 □ Yes 2 ▼ No	Hospital: 1 Inpa	atient 2 ER/Outpatie	nt 3 DOA	er: 4 🗌 Nursing Ho	me 5 🗆 Reside	ence 6 🗀 Other (S	pecify)
n of		Ë	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of li (Month,	njury 28b. Time o Day Year) Injury	of 28c. Injun Worl	y at k?	28d. Describe ho	ow injury occurred	
0	Attending ir death. ector: Afte by the fune	atic	2 ☐ Accident investiga			M 1 🗆	Yes 2 □ No			
Division	l or Attsnu after death Director: I in by the	ŧ	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Place UI	Injury - At home, farm, st etc. (Specify)	reet, factory, office		28f. Location (Si City or Town		Rural Route Number,
	urs al aral D	S	CO. Continue (Continue	Physicians Tartha ha		the consequence of the size	no data and place	and due to the e	outo(c) and manner	as etatod
	To the Hospital or Attant within 24 hours after death To the Funeral Director; completely filled in by the	Medical Certification;	29a. Certifier 1.2 Certifying (Check only 2 Medical E.	xeminer: On the basis and manner	est of my knowledge, dea s of examination and/or in stated.	nvestigation, in my o	pinion, death occur	red at the time, d	date and place, and c	ue to the cause(s)
	ro the vithin o the omple	Me	29b. Signature and title of certifier	, 11.		29c. Licens	e number	2	29d. Date signed (Mo	onth, Day, Year)
	- s + ō) and K	SA	-, ch	DIT	1694		06/06	1104
	10		30. Name and address of person w	ho completed cause of	of death (Item 23a) (Type				50/0	101
	V		Sang K. Han,				ie, MD 2	1061		
	Sta	ate	31. Date filed (Month, Day, Year)	\$2. Regi	istrar's Signature	M. 0				

State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) June 2004 **Physician** 5 Hill 5:450 M Louise /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 500 Dorsey Ave. Essex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dav. Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 M 2 KF 219-10-1048 Yrs. March8,1919 85 Director Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Itam 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic avant, the Medical Examiner must be multified at 1 Yes % No Baltimore Essex Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21221 500 Dorsey Ave. permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23a any injury or other traumath. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. S Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Martins 7th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Andrew Hill Johanna Friese ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joseph Hill / brother 35 Ridgemoor Road Baltimore MD 212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6/9/04 Baltimore MD OakLawnCemetery * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee 300 Mace Ave. Baltimore MD 21221 ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, no cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or comp. shock, or heart failure. List only Immediate Cause (Final BREAST CANCER **Physician** METASTA TIC 18 MONTH resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Physician/Medical as attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death **esn** 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f □Yes 2□No Division of Vital Records, P.O. 9 ☐ Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown FAILURE HEART Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has page 2 autopsy performed? certificate 1 Yes 2 No director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ZNO 2 ER/Outpatient 3 DOA 2 this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural within 24 hours after com.
To the Funerel Director: After 5 Pending 1 ☐ Yes 2 ☐ No investigation Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 C Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital 😰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of contine 29c. License number D45530 encularin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANDPIPERCIRCLE, SUITE 211, MD -2123 SIVAGALLAM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Dorothy Lucille Hampton June 5 2004 6:53am /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Gilcrest Center Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □ F Dec.15,1928 Virginia 75 Yrs. 223-30-9728 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location Show ral', or itams 23a or 28a-f show Exercitive Livest be notified at 1 Yes 3 No MD Baltimore Millers Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19100 Gunpowder Road 21102 USA Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker own home 6th nd 2 should be filed a lith and Mental Hygid 27 Is marked other r traumatic event, II 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should nent of Health and Men Amos P. Parks Effie V. Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Millers MD 21102 Ellis T. Hampton /son 19100 Gunpowder Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/9/04 independence PleasantGrove * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licenses 300 Mace Ave. Baltimore MD 21221 23a. Part 1. Enter the disease, or confications that caused the disease, or heart failure. List on one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) leave **Physician** me /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68769. Completed by Physician/Medical IF FEMALE 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No
9 Unknown Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 X ther (Specify) 2 1 ☐ Yes 2 No 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death I Diractor: After to in by the funeral Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🛣 artifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

orothy within 24 hours a To the Funaral L To tha Hospital

(Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25205

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Charles St. Balto, Md 21204 BMC 6701 W A

31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature JUN 0 9 2004

DOS amend item#23a,Part II,27,28a-f,PER ME,G832,6/24/04eg 04-3700 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. John Horner Jr. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Horner June 2, /Medical 2004 1756 p ^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 122 South Haven Street Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Birthplace (State or Foreign Country) 1MM 2□ F Year) 2162 43 88 Director Yrs. 1941 April Mary land Usual Residence of Decedent the Maryland 10a. State 10b. County 28a-f show 10c. City, Town or Location 10d. Inside City Limits traumatic avant, the Nedical Examiner must be notified at Baltmore Directo MATYLAND Dundalk 1. Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 282 21222 or Itams 23g United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 No Specify Specify: While 3 Widowed 4 Divorced 'natural' 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) othar than Elementary/Secondary (0-12) College (1-4or 5+) FABRICA tor permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is markad oth any linivy or other traumatic avent, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Horner DiAnz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FAther Sr 282 Mildred Ave John M. Horner Dundalk 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) MAYVIEW Cremator 2004 ture of Funeral Service Licensee 22. Name and Address of Facili Connelly Free 71 21. Sign Home Pt. Z 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

Arteriosclerotic Cardiovascular Disease Approximate Interval Between Onset and Death Friysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Dita to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death Month Day Year 5 Other (specify) ed by the a of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Atherosclerotic Cardiovascular Disease Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan page 2 1X Yes 2 □ No director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \square Nursing Home 5 \square Residence 6 \boxtimes Other (Specify) at scene ů Yes Yes 2 No Other: filled in by the funeral 27. Manner of Death Certification: After LOUMAnth, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred found or Attanding 5 Pending after death. investigation 2 Accident 1 ☐ Yes 2 🙀 No 6/2/04 4:47p unknown 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide residence 122 S. Haven St., Baltimore, MD To tha Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME June 3, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registras Signature State Reser Is April Registrar 9 2004

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 12:25 AM Kubert 2004 un /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner TOHNS HOPKINS BAYVIEW Care Center Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours **№** M 2□ F 11/19/1958 Director 216-76-0977 Maryland Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show 1 ☐ Yes 2√2 No Maryland Baltimore Middle River Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Ambo Circle 21220 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. r than "natural", or items the Medical Exeminer m 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Driver Paint 17 is marked other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert Leroy Hadel, Sr. Bernice Holste 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ortment of Health a creant: If item 27 is injury or other tree Wanda Coreen Hadel (Wife) 2 Ambo Circle Middle River, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 6/9 2004 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ortant: * 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Memorial Gard. Baltimore, Maryland permit.
Deportru
Importa
any inju 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Maryland 21221 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** nnnks Arrh m; Ca /Medical Due to (or as a consequence of): **Examiner** Diralion dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhiated events resulting in death) Last Due to (or a consequence of): Examine attending physician and for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 🗆 Other (specify) ed by the a 9 Unknown 9 Unknown been signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the irrector, page 2 si autopsy performed 1 ☐ Yes 28 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 17 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To this After this funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No nours after death 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who pleted cause of death (Item 23a) (Type, Print) 5505 Hopkins BAYVIEW 6 reenough William 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2001Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) June 4, **Physician** 2004 Anna A. Heller 8:50 a M /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1880 Trudeau Drive Forest Hill Harford 7. Age (In yrs. last birthday)

Q/i. Yrs. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Sept. 2, 1919 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 ☐ F 219-01-4414 Mary land Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or items 23e or 28e-f show 1 Yes 2 No Director Md. Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1880 Trudeau Drive Funeral United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygien Important: If item 27 is marked other than in jury or other traumatic svent, III.s. once. 12 years office supervisor money orders 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Charles Krucky Marie Hertrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dale Heller/son 2519 Burgundy Drive, Fallston, MD 21047 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Nat'l Cem. | 6/7/2004 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MAN Keci 3 mos roco:ccinama /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Year Month Dav 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 CUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an autopsy performed 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No this s after death.
I Director: After this d in by the funeral d 28a. Date of Injury (Month, Day Year) 28d. Zescribe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide within 24 hours after de To the Funerel Directo completely filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospitel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DL063 - 04 provette MD 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Arguette 65 69 N. Charles St. Sute 711; Baltmore Mp 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 9 2004 Registrar

			For State Registrer		State	of Maryla		artment of H rtificate of I		Mental Hy	giene 200	4 18172
	Physici /Medic		1. Decedent's Name Walter		ss, Jr.					2. Date of De Month JUNE	Day Ye 4, 2004	ar 4:28P. M
1	Examir		4a. Facility Name (If 1		, give street and i	number)		4b. City, Town, or FOREST	HILL		4c. County of D	
	Funeral Director		5. Social Security Nu 217-30-74 Usual Residence of I	68	6. Sex 1 ☐ M 2 ☐ F X		rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Min	. (Month, Da	rth ay, Year) 9.	Birthplace (State or Foreign Country) Maryland
	aryland show	_	10a. State	10b. County		10c.	City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the Maan or 28a-f	Funeral Director	Md. 10e. Street and Num 1618 Ross		ord		Fc	10f. Zip Code	1050		10g. Citizen of What	Country?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 Is marked other then "netural", or Items 23a or 28a-f show other traumatic event, Ite Marylan Examination at the multiple at	by Funeral	11. Marital Status 1 Never Marrie 3 Widowed 4	d 2 <mark>K</mark> Marr	12. Was De Armed 1 _ Ye If Yes, Year or	ecedent Ever in Forces? s 2 No Give Dates:	İ	Was Decedent of H If Yes, specify Cuba		Specify Yes or No rto Rican, etc.)	o- 14. Race - A	merican Indian, /hite, etc.
21215-0036	within 72 hou ene. then "netura	Completed	(Specif	, , , ,	t grade complete	d) (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done o DO NOT use retired	during most of w	orking	16b. Kind of Busine	
	2 should be filed withir and Mental Hygiene. Is marked other then aumatic event, ILEM.	Be Co	8 years 17. Father's Name (F	First, Middle,	Last)		mate	rial hand	18. Mother's N		, Maiden Sumame)	Electic
Maryland	should be and Mental Is marked or umatic eve	To E	Walter L. 19a. Informant's Nar				19b Mailir	ng Address (Street		thy Brewe	er, City or Town, Stat	e Zin Code)
	and 2 sealth an n 27 is		Mrs. Judi				163	18 Ross R			1, MD 2105	
Baltimore,	permit. Pages 1 and 2. Department of Health a Important: If item 27 is eny injury or other trau once.		20a. Method of Dispo 1 ☐ Burial 2 ☐ 1 ☐ Donation	Cremation	3 □Removal fro	m State		sition (Name of matory or other place Cremator	1	Date 3/2004	20c. Location - City Baltimor	
Balt	permit. Departi Importi eny Inj		21. Signature of Fun	eral Service	iceqsee	-6	22				of Bel Air el Air, Md	
68760,	eath certificate be executed Wedical attending physician and for use as the burial-transit	edical Examiner	shock, or heart Immediate Cause (F disease or condition resulting in death) Sequentially list con- cause. Enter Under Cause (Disease or in that initiated events resulting in death) La	ditions,	a	o (or as a cons	equence of):	er the mode of dyin	Novel	of He	vd	Approximate Interval Between Onset and Death
O. Box 68	law requires that the death certifica as been signed by the attending ph 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 n 1 Yes 2 9	nonths?	1 Live	outcome of pre- birth 2 F gnant at time of known	etal death 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
ecords, P	w requires that the de been signed by the should be detached	by	Part II. Other signific	cant condition	ons contributing to	death but not	esulting in the u	nderlying cause give	en in Part I.	23e. Did t	18.20	a to the cause of death? Probably 4 □Unknown
M	The ate h page	Completed								24a. Was auto perfo	psy prior ormed? death	autopsy findings available to completion of cause of ? 'es 2 \sum No
ion of Vital	Attending Physicien: The rideath. sctor: After this certificate his by the funeral director, page	To Be	25. Was case referred examiner? 1 Yes 2 Name of Death 1 Natural 2 Accident	√o 5 □ Pendin investig	28a. Da	Inpatient 2 se of Injury ont Day Year	ER/Outpatier 28b. Time of Injury		er: 4 □ Nursing / at </td <td>Home 5 Resi</td> <td></td> <td>pecitySCENE Telf</td>	Home 5 Resi		pecitySCENE Telf
Division	in Pitte	Certification;	3 Suicide 4 ☐ Homicide	6 □ Could r determ	ined 286. Pla	Iding, etc. (Spe	17 H	eet, factory, office		1618	Street and Number or wn state)	21050
	ne Hospital 24 hours a ne Funeral	edical	29a. Certifier (Check only 2	1∐ Certifyin 2X Medical	Exeminer: On the	he best of my libasis of exam	knowledge, deatl ination and/or in	n occurred at the tim vestigation, in my of	ne, date and place pinion, death occ	e, and due to the curred at the time,	cause(s) and manner date and place, and o	as stated. due to the cause(s)
	To the within 2 To the complet	N.	29b. Signature and to	itle of certifier	0000			29c. License			29d. Date signed (Mo	
	10	Page 100 and 1	30. Name and addre	ss of person	who completed ca	use of death (I	tem 23a) (Type,	Print)	.C.M.E.		JUNE 5,200	
			J Ak 31. Date filed (Month	Day Year	octe	M Registrar's Sig	nature	111 Penn	Street,	Baltimo	ore, Maryla	and 21201
1	Sta Registi	9	JUN (Trogistian s Sig	B 4	cours!				

			For State	State of Ma	ryland / D <i>ا</i>	epartment of F Certificate of	lealth and I Death	Mental Hygi -	ene 2004	18173
			Registrar Decedent's Name (First, Middle, La	ist)		Jorning of	Dealit	2. Date of Death		3. Time of Death
	Physici /Medio		GARY 7	YRONE	HAR	RISON		June	3 2004	23'3() PM
	Examir		4a. Facility Name (If not institution, gir	e street and number)			r Location of Death		4c. County of Dea	th
			JOHNS HOPKIN 5. Social Security Number 6.		A (In yrs. last birth	DA I Frm	いて If Under 24 Hrs.	0.5-1. (5)45	NA	
	Funeral Director		219 98 1721	Sex 7. Age 1 2 M 2 □ F		Months Days	Hours Min.	8. Date of Birth (Month, Day, April 27,	Year) 9. Bir	thplace (State or Foreign ountry) M · D
			Usual Residence of Decedent					TPICII & 1,	1782	11.2.
	h the Maryland or 28a-f show on notified at	ī	10a. State 10b. County	,	10c. City, Town					10d. Inside City Limits 1 Yes 2 □ No
	the M	Director	10e, Street and Number	a	BAItIN	10f. Zip Code	• • •	10	g. Citizen of What Co	
	23a or	Dir		54		2/2	2./	10	11.5.A.	ountry ?
	ter death	Funeral	11. Marital Status	12. Was Decedent 8	ver in U.S.	13. Was Decedent of H	fispanic Origin? (S	pecify Yes or No-	14. Race - Ame	
36	g 5 E	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 N If Yes, Give	lo	1 ☐ Yes 2 No		o riican, eic.)	Black, Whit	
5-0036	72 hours "natural", ur il Ex		15. Decedent's E	Year or Dates:	16a. D	Decedent's Usual Occup Give kind of work done	ation	1	6b. Kind of Business	
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and	ould be fil Mental H arked oth	Be	17. Father's Name (First, Middle, Las.					ne (First, Middle, M		
Maryland	2 should be and Mental Is marked or sumatic every	10	19a. Informant's Name/Relationship		19b. I	Mailing Address (Street	NANCY and Number or Ru	Chaffy	City or Town State	Zin Code)
	nd 2 salth ar 27 is		NANCY Chaffen		411	N. Bowldi	N 54 B	Altimone M	0 2/224	/
ore,	ges 1 and 2 should be filed withi t of Health and Mental Hygiene. If itam 27 is marked other than or other traumatic evant, It v. M		20a. Method of Disposition	Domaval from State	20b. Place of I	Disposition (Name of crematory or other place		Date 2	0c. Location - City or	Town, State
Baltimore,	Pag Iment tant: I		19 Burial 2 □ Cremation 3 [10 A □ Donation 5 □ Other (Speci		thing Me	MURIAL PAR 22. Name and Addre	x 6/9	9/04 2	BA Homore A	10
Ball	permit. Pages Department of Important: If i any injury or one		21. Signature of Funeral Service Lice	nsee	(5)					
			23a. Part1. Enter the disease, or con	nplications that caused	the death. Do no	1129 N. C				Z/2/3 Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition				A			Interval Between Onset and Death
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	Examiner	_	Sequentially list conditions,	b. Puo to /or as o	rolonge	idommi k	1.34			Tweek
	uted I	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (01 as a	consequence or	<i>j-</i>				
ó	an and rial-tra		that initiated events resulting in death) Last	Due to (or as a	consequence of):				
68760,	ificate be executed g physician and as the burial-transit	edicai	•	d						
	:= D0 d1		IF FEMALE:	23c. If yes, outcome	of pregnancy				204 8-4-44	
Вох	death certil e attending id for use a	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)	,		23d. Date of del Month	Day Year
P.O.	that the de led by the a detached	hysi	9 Unknown	9□ Unknown						
S,	w requires that been signed b should be det	ру Р	Part II. Other significant conditions			he underlying cause giv	en in Part I.		acco use contribute to	- 4
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Vital Record	ela has le 2	mpi	Psuchotime	comity p	ara pleg	19		24a. Was an autopsy performe	prior to death?	stopsy findings available completion of cause of
每	(C) 6-6-	Φ	25. Was case referred to medical	- corebri			26 Place of Dea	th (Check only one,		38 No
of <	8 5	To B	examiner? 1 XYes 2 ☐ No	Hospital: 1 Inpatie	nt 2 ☐ ER/Outp	atient 3 DOA Oth			ce 6 ☐Other (Spe	cify)
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Sivision	Attending or death. actor: After by the fune	licat	2 Accident investigation 3 Suicide 6 Could not t	De Diago of Inju	rv - At home, fam	M 1	Yes 2 □ No	28f. Location (Stre	et and Number or Ru	ural Route Number
Ö,	s after s after al Dira	Certification:	4 Homicide determined	building, etc	. (Specify)	, , , , , , , , , , , , , , , , , , , ,		City or Town,		
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai (29a. Certifier Certifying P	hysician: To the best of miner: On the basis of	f my knowledge,	death occurred at the tin	ne, date and place	, and due to the cau	ise(s) and manner as	stated.
	thin 24 thin 24 tha F	Med	29b. Signature and title of certifier	and manner sta	ed.	29c. Licens			d. Date signed (Monti	
	5 × 5 8		· ////	1. Alla	A A		- 000			d 2004
	2	1	30. Name and address of person who	completed cause of de	ath (Item 23a) (T				, ,	,
			DANIEL SCIUB			WOLFE ST	BALTI	MORE , n	0 2128	7
	Sta Registi		31. Date filed (Month, Day, Year) JUN 0 9 2004	32. Registra	r's Signature	ha de				
	riegisti		SAIN OS COOA		10 1	NURA				

			1 - For Stata Registrar	State of Mary	· ·	artment of F			ene . No.2004	18171
			Decedent's Name (First, Middle, La	st)				2. Date of Death		3. Time of Death
	Physici		JACQUELINE HOAG					Month JUNE	Day Year 4 2004	0430 M
	/Medio Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	r Location of Death	JONE	4c. County of Death	
	LAGIIII	ICI	OD44 CHMMIT HILL WAY			ILCCID			AA CO.	
	Funeral		5. Social Security Number 6.5	iex 7. Age (Ir	yrs. last birthday)	JESSUP If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
н	Director		085.54.9217	□M 2∏F	71 Yrs.	Months Days	Hours Min.	(Month, Day, Y MAY 7, 19	33 ENGI	intry) LAND
			Usual Residence of Decedent			·	1			
	/land		10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	Mar Mar	to	MD AA CO.		SEVERN					1 ☐ Yes 2 ☐ No
	1 the	Director	10e. Street and Number			10f. Zip Code		10g	g. Citizen of What Cou	ntry?
	38 oi		131 TELEGRAPH ROAD			21144			USA	
	ns 2	Funeral	11. Marital Status	12. Was Decedent Eve	r in U.S. 13.		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri	can Indian,
	fier of	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No			an, Mexican, Puerto	Rican, etc.)	Black, White,	etc.
336	ars a	b	3√Widowed 4 □ Divorced	If Yes, Give XX Year or Dates:		1 □ Yes 2ÑX No	Specify:		Specify: WH	ITE
ŏ	72 hours after death with the Maryland naturel; or Items 23e or 28e-f show deat Examiner must be notified at	ed	15. Decedent's E		16a. Dece	dent's Usual Occup	ation	16	6b. Kind of Business/Ir	
21215-0036	C * (3)	Completed	(Specify only highest gri	College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of work d)	ing		
212	filed within Hygiene. Hygiene. other than "lent, ine Mac	E	12	00//dge (1-40/ 3+/	SALES	ASSOCIATE			RETAIL INDUS	STRY
	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "naturel", or Items 23e or 28e-f show other than "naturel", or Items 23e or 28e-f show event, Ite Medical Examiner must be nutified at	Bec	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, Ma	iden Sumame)	
Maryland	should be filed within the Mental Hygiene. marked other than imatic event, Ire M	ToB	WILLIAM WEBB				REBECCA (CREENE		
ary	2 should and Men Is marke eumatic	_	19a. Informant's Name/Relationship	Type, Print)	19b. Maili	ng Address (Street			City or Town, State, Zi	o Code)
	로 5 로 로		DEBRA_SOMMERS		2211	SUMMIT HILL	WAV TEECH	MD 20794		
altimore,			20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place			c. Location - City or T	own, State
e E	0 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci		•	-		0001	E. E	
量	permit. Pag Department Importent: I any injury o		21. Signature of Puneral Service Live		THE RESERVE AND ARRESTS AND ARRESTS AND	CFMFTFRY 2. Name and Addre	JUNE 9	3, 2004	FLEMING, NY	
Ba	permit. Departr Importe any inju	1	*Cucordo	July 1		NK FUNERAL				
	_		23a, Part I, Enter the disease, or con	M01			SW GLEN BL			Approximate
в			23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	1-1	1.				Interval Between Cheet and Death
	/Medical		disease or condition resulting in ceath)	a	2 Jeste	uc DI	in Ca.	hcヤ/		X mas
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	the d	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	9 01 0 0 4(ii) 5 [
P.0	that the de led by the a detached f		Part II. Other significant conditions	contributing to death but n	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
Records,	20 00	l by						1 12 Yes		bably 4 □Unknown
Ö	w require been si should	Completed								
ec	e law has t	ldu						24a. Was an autopsy	prior to co	opsy findings available impletion of cause of
=		S						performe 1 ☐ Yes 2 Z	TNo 1 ☐ Yes	20 No
Vital	Physicien: The this certificate ral director, page	Be	25. Was case referred to medical examiner?	He anitale		100		h (Check only one)	0.4	1
of	Physic this c	မ	1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatier		4 Nursing no	me 5 Residence		fy)
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sio	eath. or: A	cati	2 Accident investigation 3 Suicide 6 Could not to				Yes 2 □No			
Division	irect irect	Certification;	4 Homicide determined		- At home, farm, sti Specify)	reet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
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	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical	(Check only 2 Medical Exa	nysician: To the best of m miner: On the basis of ex	amination and/or in					
	the the	Med	29b. Signature and title of certifier	and manner stated		29c. Licens	e number	29d	. Date signed (Month,	Day Vear)
	To To	-	250. Signature and the of Centimer	1/1)	1	25c. Licens	712)	Take Signed (Moritor,	2 110/1
	.\		1/1/sa				115	/	4164,	2004
	V		30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print	Jal n	: C1	6. Ri.	m/ >101.1
			31. Date filed (Month, Day, Year)	32. Registrar's	Signature	17010	rul D	FIVE OF	ry wony	4-100/
	Sta Regist	ate rar	JUN 0 9 2004	Zen Las	Ag .	land,		-	,	
	Liegisi	15.1	0011 0 0 2004	1	100	green/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1:12 PM **Physician** ones 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sinai Hospita Baltimore of Baltimone If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Davs | Hours | Min. | Month, Day 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 102M 2□ F 312-70-7180 Months Days Director 24, 1957 Marylano Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits or 28e-f show other treumatic event, the Medical Examinar must be notified a 1 es 2 No Baltimore Completed by Funeral Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 52 23RD 21218 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 WNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 ក Specify: Specify: Black 3 Widowed 4 Divorced "naturet" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be a n and Mental Kobert Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is m any injury or other treum once. Baltimore, Jeniffer 2318 teard Sister mD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Randallstown, mo King Memorial Park 6-12-04 75 ☐ Other (Specify) * 4 Donation uneral Service Licent 21229 P. March FIH 270 Fredhilton Pass Balto, mx Epfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End Stage AIDS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Acute Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Sep 525

Due to (or as a consequence of): for use as the burial-transit The law requires that the death certificate be executed Anemia Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, disorder, HIV encephalopath 1 Yes 2 No 3 Probably 4 Wunknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 I No 24a. Was an autopsy rmed2 2 No 1 Yes To the Hospitel or Attending Physicien: director 25. Was case referred to medical 26 Place of Death (Check only one) examiner' Hospital: 1 ▼Inpatient 2□ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3□ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident investigation 6 □ Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 8,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Haylord M.D., Sinai Hospital 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 0 9 2004

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra AMEND ITEM #2&4c PER PHY G832 Certificate of Death 2. Date of Death JUNE 4,2004 **Physician** 6,2004 /Medical Facility Name (If not institution give street and number) NG &HOSPITAL BOLL TOWN, or Location of Death LEVINDALE, GERTATRIC NURSING &HOSPITAL BOLL MOVE 4c. County of Death Examiner Baltimore NIA If Under 24 Hrs. 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2\F Director Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23e or 28e-f show the Medical Exercise must be matified at Baltimore 1 Yes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe venue filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Hygiene. hurch Clerk other Mother's Name (First, Middle, Maiden Surname, permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Importent: if Item 27 is marked oth any linjury or other treumstic event <u>once.</u> Be Whitman HOHOM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Date 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 ☐ Cremation 3 ☐ Removal from State 6-11-04 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn CGreene Funeral Srus 21. Signature of Funeral Service Licensee ndallotown modiliza 23a. Part1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician System c yrs /Medical Due (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Month 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown RENAL 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2/ No 2□ No 1 TYes Division of Vital fo the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Manner of Death 28d. Describe how injury occurred Medical Certification: 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 6, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SWestha 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 9 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6 Krebs QUITA

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 ☑ No

04

Md

Black, White, etc.

Month

Dav

Year

8:45 AM

Physician /Medical Examiner

4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Barview
6. Sal Balkwore Baltimore Medical Leuter 8. Date of Birth (Month, Day, Tune 3 **Funeral** Hours Min. 1 M 2 TF 218-84-6452 40 Director 1963 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ir than "natural", or Itama 23a or 28a-f show the Modest Examirer must be notified at MdHoward Jessup Funeral Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8255 Savage Guilford Rd. 20794 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A or Itama Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian. filed within 72 hours after 1 ☑ Never Married 2 ☐ Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: white Completed by 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) food service waitress 12 other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) .. Pages 1 and 2 should be fill thent of Health and Mental Heant: If item 27 is marked other ury or other traumatic even Be Phillip Krebs Marjorie Streaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Krebs (brother) 8038 Round Moon Circle, Jessup, Md 20794 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or Sykesville, Md *4 □ Donation 5 □ Other (Specify) All County Cremation | 6-4-04 22. Name and Address of FacilityHaight Funeral Home & Chap permit. 21. Signature A Funeral Service Licenses P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner burial-transit The law requires that the death certificate be executed P.O. Box 68760 physician use as the IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal deal 4☐Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 DEctopic pregnancy for in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 Mo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, Be Completed al director, page 2 should this certificate has been 24a. Was an autopsy performed? 1 Yes 2 No or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Yes 2 No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After 5 Pending investigation 1 Natural death. 1988 UNKNOWN 1 ☐ Yes 2 XNo 2 Accident the within 24 hours after deatl To the Funeral Diractor: 6 Could not be 3 ☐ Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital 29a. Certifier Medicai To the I

23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) , columbia MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) RES 001 ted cause of death (Item 23a) (Type, Print) Medical Center, 4940 Easton Ave. ollus **ORIGINAL**

State Registrar

	ľ	1 - For State Registrar	State of Maryla	and / Dep	artment of rtificate of	Health and M	Mental Hyg	giene 200	4 18178
Physicia /Medic		Decedent's Name (First, Middle, Lass William	L.	Lange	nfelder		2. Date of Dea Month June 5,	2004 Ye	19:48 PM
Examin Funeral	er	4a. Facility Name (If not institution, give Johns Hopkins - B 5. Social Security Number 6. S	ayview Center	s. last birthday)	Baltin	r If Under 24 Hrs.	8. Date of Birth (Month, Day	4c. County of D N/A	eath Birthplace (State or Foreign Country)
Director		215-30-5469 12 Usual Residence of Decedent 10a. State 10b. County	ØM 2□F	71 Yrs. City, Town or Le		s Hours Willi.	November	21,1932	MD. 10d. Inside City Limits
h the Man or 28a-f sh	irector	MD N/A 10e. Street and Number		Baltimo	ore 10f. Zip Code		1	10g. Citizen of What	1 XYes 2 No Country?
if it is within 72 hours after death with the Maryland Hygiene. Hygiene, the Hygiene state is now inter then "neturel", or items 23e or 28e-f show ent, the Msdical Examiner must be nutified at	by Funeral Director	7313 Bridgewood D	12. Was Decedent Ever in Armed Forces? 1XX es 2 □ No If Yes, Give Year or Dates:	U.S. 13.	212 Was Decedent of If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	11157.1	umerican Indian, thite, etc. White
within 72 hou ana. than "natura he Medical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 10 years	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occ kind of work don DO NOT use reti	e during most of wor red)		16b. Kind of Busine	ess/Industry Energy System
2 should be filad with and Mental Hygiana is marked other tha aumatic event, the sumatic event, the sumatic event, the sumatic event.	To Be Co	17. Father's Name (First, Middle, Last) John L. Langenfe	lder	naci	HILLSC IC		ne (First, Middle,	Maiden Sumame)	mergy bysec.
s 1 and 2 should be filed within 72 h f Haath and Mental Hygiane. Item 27 is marked othar than "natur other traumatic event, the McGical		19a. Informant's Name/Relationship (7) Shirley Langenfo 20a. Method of Disposition	elder wife	7313	•	et and Number or Ru od Drive,			224
permit. Pages 1 and 2 Department of Health s Importent: If item 27 is any injury or other tre		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	LC	oudon Pa	rk Cemet 2. Name and Add Onnelly	cery Funeral H	2004 ome Of D	Baltimore	Α.
Physician /Medical Examiner perial-transit	dical Examiner	23a. Par 1. Enter the disease, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	bilications that caused the dependence cause on each line. a	equence of):	THU SOT.	ters Point	. Road, L	undark, Mr	Approximate Interval Between Onset and Dyth Washington Minny
ha daath certifi	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pred 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3	⊒Ectopic pregnar ⊒ Other (specify)	icy		23d. Date of Month	delivery Day Year
The law requires that the death certificate the has been signed by the attending phys page 2 should be detached for use as the	Completed by Ph	Part II. Other significant conditions o	ontributing to death but not r	resulting in the u	undertying cause	given in Part I.	1 □ Y	es 2 No 3	e to the cause of death?] Probably 4 Unknown a autopsy findings available
n: The la	e Comp	25. Was case referred to medical				Of Diago of Dog	autops perfor 1 ☐ Yes	mod? death	
To the Hospital or Attanding Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attanding physicomplately filled in by the funeral director, page 2 should be detached for use as the	Certification; To B	examiner? 1 Yes 2 16 27. Nanng-of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - A	t home, farm, st	of 28c. In W	ork? Yes 2 No	ome 5 Residue	ence 6 Other (Sow injury occurred	Specify) r Rural Route Number,
For the Hospital or Attanding within 24 hours after death. To the Funarel Director: After completely filled in by the fune from the fune for the fune for the fune for the fune for the fune for the fune for the fune fune for the fune fune for the fune fune for the fune fune fune fune fune fune fune fun	edical Certi	29a. Certifier Certifying Ph	building, etc. (Spe ysicien: To the best of my hiner: On the basis of exam	ecify) knowledge, dea	th occurred at the	time, date and place		ause(s) and manne	
To the I within 24 To tha F complate	Medi	29b. Signature and title of dentities	and manner stated.		29c. Lice	13879		29d. Date signed (M	
Sta		30 Minne and address of person who have the state of person who have the s	ompleted cause of death (I	JEI.YV	Mount	Are.	16w3	en M	2 21286

			1 - For State Registrar		ryland / Depa <i>Ce</i>	artment of H rtificate of L		Re	g. No 2006	18179
п	Physici	an	1. Decedent's Name (First, Middle, Las					Date of Death Month	Day Year	3. Time of Death
	/Media	cal	Violet R. Lellyc			4b. City, Town, or	Location of Death	June 7	2004	4:40 P M
1	Examir	ier	Genesis Eldercare		le	Centrev		1	4c. County of Dear	
	Funeral		Social Security Number 6. S	ex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	~	hplace (State or Foreign
ш	Director		209 20 6994	□ M 212 F 7	5 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Sept. 25,	1928 Penr	nsylvania
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryl -f sho	tor	Maryland Queen Ar	nes		n Anne				1 ☐ Yes 2 ☐ No
	r 28a	irec	10e. Street and Number		20.00	10f. Zip Code		10	g. Citizen of What Co	
	23a c	Funeral Directo	313 Laurens Way			21657			USA	
	r dea	ne	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ XWidowed 4 ☐ Divorced	1 ☐ Yes 2 🛣N If Yes, Give Year or Dates:	0	1 ☐ Yes 2 🗷 No	Specify:		Specify: Wh	
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show he Medical Evanthur must be notified at	ted	15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occupa	ition	16	6b. Kind of Business/	Industry
215	thin 7: e. en "n	Completed	(Specify only highest gra	de completed) College (1-4or 5-	(Give	kind of work done d DO NOT use retired)	luring most of wor)	king		,
7	ygien ygien yer th	Con	12			pist			Aerospace	<u> </u>
Maryland	be fill ad off even	Be	17. Father's Name (First, Middle, Last) Adam Lizbinski				18. Mother's Nan	ne (First, Middle, Ma	aiden Sumame)	
N	hould d Mer mark maric	2	19a. Informant's Name/Relationship (7	Type Print)	10h Mailir	og Address (Street a			City or Town, State, 2	Fin Code)
≥	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 ie marked other then "neturel", or Items 23a or 28a-f show other treumatic event, The Medical Examinar must be notified at	1	- 1 - 11	son)		Laurens Wa			aryland 21	
Je,	item item othe		20a. Method of Disposition		20b. Place of Dispo	sition (Name of		Date 20	C. Location - City or	
Ë	Page nent c ent: If ury or		1 🔀 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify		Md. Veter	ans Garri	ison 6/10	0/2004 G	arrison Fo	prest
Baltimore,	permit. Pages 1 and 2 should be filed within Deparament of Health and Mental Hygiene. Importent: if item 27 is marked other then 'any injury or other treumatic event, The Ma ODGe.		21. Signifure of Fundal Serve Licen	Sec -	A 22	Name and Address	s of Facility	al Home P	Δ	
	40 E # 9		4-12			1407 Old E	Eastern <i>I</i>	Avenue Ess	sex, Md. 2	
N.	Priysician /Medical		23a. Fart1. Enter the disease, or come a lock or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	a	Myou	in Ji w	r n fax		t,	Approximate Interval Between Onset and Death
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8760,	death certificate be executed e attending physician and id for use as the burial-transit			Due to (or as a	consequence on:					
687	ficate physics the	edic		. d						
Вох	leath certifica attending ph I for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		T-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1			23d. Date of deli	very
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ds,	ires that signed t d be det	d by	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the ui	nderiying cause give	n in Part I.	23e. Did toba	cco use contribute to 2 Pro 3 ☐ Pro	the cause of death?
Records,	w require been signal	etec								
Re	9 4 9	Completed						24a. Was an autopsy performe	d? prior to death?	topsy findings available ompletion of cause of
Vital	ician: Th certificate rector, pag	0	25. Was case referred to medical				26 Place of Dear	1 ☐ Yes 2 ☑ th (Check only one)	No 1 ☐ Yes	2 No
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n of	ding Ph h. After th funeral		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	28c. Injury Work		28d. Describe how		
Sio	Attending in death. ector: After by the fune.	cati	2 Accident investigation 3 Suicide 6 Could not be				es 2□No			
Division	o it to	Certification:	4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, farm, stre (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru. State)	ral Route Number,
	To the Hospitel or A within 24 hours after To the Funeral Dire completely filled in b	edical Co	29a. Certifier (Check only one) 1 Certifying Phy 2 Medicel Exemption	ysicien: To the best of hiner: On the basis of and manner stat	examination and/or inv	occurred at the time restigation, in my opi	e, date and place, inion, death occur	and due to the cause	se(s) and manner as and place, and due	stated. to the cause(s)
	To th. within To the	Me	29b. Signature and title of certifie			29c. License			. Date signed (Month	
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	V		30. Name and address of person who co	Sorwy	ath (Item 23a) (Týpe,	Print) Donal	n Drive	Chart	6/8/30 0, MJ 21	619
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 9 2004	32. Registrat	's Stinature	eks				

			1- For State of Maryland / Dep	partment of Health and I Pertificate of Death		giene200	18180
	Physici /Medic		Decedent's Name (First, Middle, Last) INEZ LOVE		2. Date of Dea Month	Day Year	3. Time of Death
Ł	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of De	ath
1			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Baltino (C)	S. Date of Birth	N/A	introduce (Change Co.
	Funeral Director		229–18–5666 1 M 2 LF 88 Yrs.	Months Days Hours Min.	05-06-	/, Year) (irthplace (State or Foreign Country) NJ
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation	100 00		10d. Inside City Limits
	Maryli -f sho	tor		ALLSTOWN			1 Yes 2 No
	ith the	Funeral Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What (Country?
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0	72 hours after death with the Marylan "neturer", or flems 23a or 28e-f show rdical Examinat must be mulfilled at		Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 🕅 No	Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerto	pecity Yes of No- o Rican, etc.)		nerican Indian, lite, etc.
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11 y 10	and Men is marke		GEORGE LAWRENCE DENT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				Zio Code)
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ע	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		TYLIBUTIAL 2 Cremation 3 Chemoval from State	ematory or other place)		20c. Location - City o	
	nit. Pa antmen ortent: injury		V	GREEN CEM . 06	-10-200	, I	Chester, PA
0	permit. Departn Importe any inju		Bus Havell &	Howell Funer	Q Hom	4600 Liber	4 Note Bato
			23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between				
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	cate be executed physician and the burial-transit	dical E	d				
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		BeC	25. Was case referred to medical examiner?	26. Place of Deal	1 Yes 2 th (Check only on		s 2 No
	fter th	2	1 Yes 2 Nursing Home 5 Residence 6 Other (Specify)				
5		Certification:	27. Manner ob Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 2 □ Accident Investigation M 1 □ Yes 2 □ No			and the second s	
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ב ב	pital o	Cel	29a. Certifier 1 Certifying Physicien: To the best of my knowledge, deal	the constraint of the time and the condition			
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1	vithir To th	Me	29b. Signature and title of certifier	29c. License number		9d. Date signed (Mon	
	O,		1-ahmad MD	Ke3-000		Tune 6	th. 2004
	1		30 Name and address of person who completed cause of death (Item 23a) (Type	Since Hospite	al of	Baltin	th 2004
	Sta Registr		31. Date filed (Month, Day, Year) . 32. Registrar's Signature .	land o			
	ricgian	aı	JUNUS COURT ACTION A	STORING TO STORY			

		- State Registrar AMEND] 1. Decedent's Name (First, Mid)							2. Date of D		Light Cy		ime of De	eath
Physicia Medic/		Edmond		Da	niel		La	Rue	Jr.		Month June	5		004 6:	30	рΜ
Examin	-	4a. Facility Name (If not institut	_				4b. City,	Town, or	Location of	of Death		40	c. County	of Death		
	14	1190 Monie Ro 5. Social Security Number	6. Se			and third are a		nton	If Under	24 Hrs	0 D-1(D)		Anne	Arundel		
uneral irector		126-07-4338		M 2□F /. A	ge (In yrs. Ia 82	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D	ay, Year		9. Birthplace (S Country) New Yor		-oreign
		Usual Residence of Decedent									July :	1.0,1	921	New TOL	Λ	
rai', or Itams 23a or 28e-f show Examiner must be nellfied at	_	10a. State 10b. Coun	ty		10c. City,	, Town or L	ocation								ide City	
100	Director	MD Anne	Arun	de1	00	dento									Yes 2	Μω
T T	급	10e. Street and Number					10f. Zip		10			10g. C		/hat Country?		
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Act ull bit	by Fun	1 ☐ Never Married XX M.		Armed Forces' 1 X Yes 2 ☐ If Yes, Give Year or Dates:	No		If Yes, spec 1 ☐ Yes 2	_	Specify:	i, Puèrto	ecify Yes or N Rican, etc.)			c, White, etc.		
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		17. Father's Name (First, Middl	2 (2st)	2		Mail	Carri		10 Motho	ela blama	(First, Middle			Servic	e	
	Be	Edmond LaRue	s, Lasi)									, Maidei	n Sumame	9)		
mati	၉	19a. Informant's Name/Relatio	nship (T)	rpe, Print)		19b. Mail	ing Address	(Street a			Hogan	er. City	or Town. S	State, Zip Code)		
othar treumatic	1	Donald A. LaF					-							Missou	ri 6	4834
otua		20a. Method of Disposition	- 0-			ace of Disp	osition (Nam	ne of	Т	-	ate			City or Town, Sta		
<i>i</i>		1 ☐ Burial 2X Cremation 1 ☐ Donation 5 ☐ Other			'		remato			6/9/2	2004	Bal:	timor	e, MD		
OUCE.		21. Signature of Suneral Safvio	e Licens	4/1		2	2. Name and Hard 12 R	esty	s of Facilit Fune	eral	Home,	P.A.		D 21401		
ician dical niner	ler	23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to monodate.	st only o	Due to (or as	s a conseque	ence of):	Ken	or dying	S, such as	Cardiac	r respiratory a	irrest,		Interv	ximate al Betwee and Dea	
ie burial-transit	Exal	rany hading to manadate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	١	Due to (or as	s a conseque	ence of):										
for use as the	//Medical	IF FEMALE: 23b. Was decedent pregnant	2	3c. If yes, outcome								- 1	23d Date	of delivery		
	hysiclan/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		1 □ Live birth 4 □ Pregnant a 9 □ Unknown			⊒Ectopic pre ⊒ Other (spe						Mon		Yea	ır
	by P	Part II. Other significant condi	tions cor	ntributing to death t	but not resul	ting in the u	underlying ca	use give	n in Part I.				_	bute to the caus		
page z snould	ompleted										24a. Was auto perfe		de	ere autopsy find for to completion eath?	of caus	alable se of
ō	BeC	25. Was case referred to medic examiner?	_						26. Place	of Death	(Check only					
the funeral dire	2	1 Yes 2 (No 27. Manner of Death 1 Natural 5 Pend	101	fospital: 1 ☐ Inpati 28a. Date of Inju (Month, Da	urv 2	P/Outpatie 28b. Time of Injury		Bc. Injury Work	at Nu	2	ne 5 ☐ Resi 28d. Describe	-			11/2	5
٠	Certification;	3 ☐ Suicide 6 ☐ Coul	-	28e. Place of In building, e	jury - At hon tc. <i>(Specify)</i>	ne, farm, st	reet, factory,	, office		1	28f. Location (City or To	Street ai wn, State	nd Numbe a)	r or Rural Route	Number	
pietery illies in	edical	(Check only 2 Medic	al Exami	sician: To the best nar: On the basis of and manner st	🔾 examinatio	rledge, dea on and/or ir	vestigation,	in my opi	inion, deat	d place, a	and due to the ed at the time,	date an	d place, ar	nd due to the ca		
completely	Σ	29b. Signature and Me of pertin	H	- K	Carl	Zn		D 2	number	94	/	06	te signed	(Month, Day, Ye	ar)	
1.531		30. Name and address of perso	m who as	impleted cause of	deat lloan	23a) vpe.	Print) .		Λ	1	A	. 1	5 A 1			

COS 04-03777 Jeffrey M. Lewis

unpend item#23a,27,28a-f,PER ME,C832,6/22/04eg Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 18 18 2

			For State of Maryland / Dep State of Maryland / Dep State of Maryland / Dep	artment of Health and N <i>rtificate of Death</i>		ene2004 18182
	Dhysisi		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
	Physici /Medic		Jeffrey M. Lewis		June 6,	2004
1	Examin	ęr	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Crownsville		4c. County of Death
		-	1266 Sunrise Beach Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.	8 Date of Birth	Anne Arundel
	Funeral Director		214-96-0428 1MM 2□F 38 Yrs. Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day,) March 3,	9. Birthplace (State or Foreign Country) 1966 New York
	yland		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	h the Maryland r 286-f ehow	tor	MD Anne Arundel Crownsv	ille		1 ☐ Yes 2x ☐ No
	with the Maryland to or 28e-f ehow	Oire	10e. Street and Number	10f. Zip Code	10g	g. Citizen of What Country?
	death w	rail	1266 Sunrise Beach Road	21032		USA
Maryland 21215-0036	nit. Pages 1 and 2 should be filled within 72 hours after death with aritment of Haaith and Mental Hygiene. ortant: if item 27 is marked othar then "naturel", or items 23e or injury or other traumatic event. It is Mcdical Examiner must be 8.	by Funeral Director	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
5-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed) (Give	dent's Usual Occupation	16	b. Kind of Business/Industry
2	12 should be filed within hand Mental Hygiene. 7 is marked othar then "traumatic event, It e Max	nple	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of work DO NOT use retired)	,,,,g	
121	iled w tygier thar th		2 Cert 17. Father's Name (First, Middle, Last)	ified Appraiser	- (5) - 14) - 14	Real Estate
anc	d ba f intal h ed of	Be o	Samuel T. Lewis, Jr.		e <i>(First, Middle, Ma</i> cia Gee	iden Sumame)
Z	should nd Me mark matic	P		ng Address (Street and Number or Rur		City or Town State Zin Code)
	nd 2 : alth ar 27 is r trau			Sunrise Beach Roa		
ře,	s 1 a of Haa item		20a. Method of Disposition 20b. Place of Disposition			c. Location - City or Town, State
<u>E</u>	Page ment c		TABUILL 2 Cremation 3 Chamboar nom State		/2004 G1	reensboro, MD
Baltimore,	permit. Pages 1 and 3 Department of Haalth Important: if item 27 eny injury or other tra once.		21. Signature et Funeral Service Licensee 2	2. Name and Address of Facility Hardesty Funeral 12 Ridgely Avenue	Home, P.A	Α.
	nệ Ý		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			
	Physician	9 1	Immediate Cause (Final disease or condition Narcotic (Heroin) Inte			Onset and Death
1	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
	LAGITITIE	_	Sequentially list conditions, bb.			
	tad nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)			
	tificate be executad ig physician and as the burial-transit	Examiner	Cause (Disease of influer that initiated events resulting in death) Last C. Due to (or as a consequence of):			
68760,	le be sicia e bur	ledical	d			
	rtificat ng phy as th		(CECTALIC			
). Box	requires that the death cer een signed by the attendin hould be detached for use	Physiclan/I	1 Yes 2 No	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
P.0	hat the d by I	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the u	adorhing assess asses in Part I	23a Did tahaa	and the course of death?
ords,	w requires to been signe should be c	ted by	Tax is other significant conditions contributing to death but not resulting in the b			co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Records,	yeicien: The law r is certificate has be director, page 2 sh	Completed			24a. Was an autopsy performed	
Vital	ien: rtifica stor, p	a)	25. Was case referred to medical	26. Place of Death	1 Yes 2 L	No Yes 2□ No
\	Physicien: this certific ral director,	To B	examiner? ★ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	04		e 6 Nother (Specify) at scene
n of	ding Ph I. After th funeral		27. Manner of Death 1 Natural 5 Pending Injury 1 Natural 5 Pending Injury 1 Natural 5 Natural Injury 1 Natural 5 Natural Injury 1 Natural 1 Natural Injury 1	28c. Injury at Work?	28d. Describe how	injury occurred
Sio	Attending r death. sctor: After by the fune	cati	2 Accident Investigation 0/6/U4 Unknow		inknown	
Division	for Attendated after death	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, S	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat			e Beach Rd., Crownsville, M
	e Ho:	edical	(Check only one) Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurr	ed at the time, date	and place, and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and little of certifier	29c. License number		Date signed (Month, Day, Year)
	1		((Shem))	OCME	J	une 7, 2004
	1,0		30. Name and address of person who completed cause of death (Item 23a) (Type,	111 Penn Street	, Baltimo	re, Maryland 21201
	Sta		31. Date filed (Month, Day, Year) . IUN 0 9 2004 . Registrar's Signature	A. I		
4	Registr	ar	JUN 0 9 2004 Jane & Agree			

State of Maryland / Department of Health and Mental Hygiene2004

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Physician /Medical Examiner

Funeral

Director filed within 72 hours after death with the Maryland 28a-f ehow item 27 ie marked other than "natural", or items 23a or 28a-f ehov other traumatic event, tre Modical Examinar must be notified at nd Mental Hygiene. marked other than

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be Health and Mental

Physician /Medical Examiner

permit. Pages
Department of It
important: if Ite
any injury or of

and I-transit the death certificate be executed sician al burial-t as nse signed to page 2 should Attending Physician: within 24 hours after deatl To the Funeral Director:

2

1 - State Registrer Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 6, 2004 Year JUNE 0932 A^M LEWIS HARTMAN G. 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) ST.AGNES HOSPITAL BALTIMORE CITY NA If Under 1 Year If Under 24 Hrs.
Months Days Hours Min 8. Date of Birth (Month, Day, Year) NOV. 15, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 🕅 F Yrs. 218-70-5327 57 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1X Yes 2 No MD NA BALTIMORE Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 63 N. MORLEY STREET 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: AFRICAN 1 ☐ Yes 2 No Completed by 3 Widowed 4 Divorced AMERICAN 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th TRUCK DRIVER TRUCKING COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HARTMAN G. LEWIS ANNIE R. LEWIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) LEWIS (WIFE) 63 N. STREET MORLEY BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ZION CEMETERY 6/11/04 LANSDOWNE. MD 21. Signature of Juneral Service Licenses 22. Name and Address of Facility WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 1/2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) -Anging Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Dectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed 1 ☐ Yes 27 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient XXER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XXYes 2 □ No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 1 Natural 5 Pending SUBJECT HATTER SOLF

28t. Location (Street and Number or or Rural Route Number,
City or Town, State) 63 South Mostley STVER WKIGWIN AM 6 04 1 ☐ Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) BAHIMOVE residence mD 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E JUNE 7, 2004 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person JACK M. Titus, M.D. 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature



DHMH 17 Rev 1/2001

Registrar

JUN 0 9 2004

	ga .	State Registrar 1. Decedent's Name (First, Middle, Las	*)	Cert	ificate of	Death	2. Date of Dea	leg. No.	2001	3. Time of Do
hysici /Medic		FRANKLIN	BERNARD	1	MALLORY		Month JUNE	3,	Year 2004	2:40
xamin		4a. Facility Name (If not institution, give	street and number)			Location of Death		4c. 0	County of Dea	
	it at	724 Springloch Ro 5. Social Security Number 6. Se		Look high doub	Silve If Under 1 Year	r Spring If Under 24 Hrs.	0 D-4(Ei-4)		ntgomen	
neral ector			X M 2□F 72	s. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day March 3	', Year)	932Was1	thplace (State or Fountry)
Now.		10a. State 10b. County	10c. C	City, Town or Loc	ation					10d. Inside City
s marked other than "neturel, or fems 2.5s or 2.8s-1 show umstic event, the McCical Examiner must be notified at	Director	Maryland Montgom	ery	Silve	r Spring					1 ☐ Yes 2
E or 2	Dire	10e. Street and Number			10f. Zip Code		1		en of What Co	•
N9 23	Funerai	724 Springloch Ro	12. Was Decedent Ever in	U.S. 13. W	as Decedent of H		ecify Yes or No-		ted Sta 4. Race - Ame	
niner	Fun	1 Never Married 2X Married	Armed Forces?	29/55		ispanic Origin? (Sp in, Mexican, Puerto	Rican, etc.)		Black, Whit	
E	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 01/	30/57	Yes 2 No	Specify:			Specify: W	nite
Deta	Completed	15. Decedent's Edi (Specify only highest grad		(Give k	int's Usual Occup ind of work done of O NOT use retired	during most of work	ing	16b. Kin	d of Business	/Industry
The Maria	dmc	Elementary/Secondary (0-12)	College (1-4or 5+) 4	Histo		"/		Free	e Lánce	
ent, I	Be Co	17. Father's Name (First, Middle, Last)	4	IIISLO.	LIAII	18. Mother's Nam	e (First, Middle,			-
tic ev	10 B	Harold Bernard Ma	llory			Virginia	Marie S	Schau	ım	
acma acma		19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailing	Address (Street	and Number or Rur	al Route Number	r, City or	Town, State, a	Zip Code)
nar tr		Joan M. Mallory/S	•		The second of the second	h Road; S	-			
or other tra		20a. Method of Disposition 1 Burial 2 XCremation 3 Disposition		Place of Disposi cemetery, cremi	tion (Name of atory or other plac	(e)	Date	20c. Loc	ation - City or	Town, State
rran.		* 4 □ Donation 5 □ Other (Specify)				tory 06/0			imore	
Important: If item 27 is marke eny injury or other traumetic QDGE.		21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or comp	Dillino	104	40 Rockv	s of Facility bute Fune ille Pike	; Rockv	ille,	nation MD 20	Center 0852
budsetian and dical ransit sthe parial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. COLON CARC Due to (or as a conse b. Due to (or as a conse c. Due to (or as a conse d.	equence of):	TASTATIO					
be detached for use as	Physician/Med	in the past 12 months?	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	tal déath 3 ⊟E	ctopic pregnancy Other (specify)			23	d. Date of dei Month	ivery Day Yea
detach		9 ☐ Unknown Part II. Other significant conditions co		esulting in the unc	lerhing cause give	an in Part I	23e Did tol	nacco use	e contribute to	the cause of deat
should be	ed by									obably 4 Dunk
age 2 sho	Completed						24a. Was a autops perform	ned?	prior to death?	itopsy findings ava completion of caus
tor. p	Be C	25. Was case referred to medical				26. Place of Deatl	1 Yes 2		T Yes	2□ No
direc	ToB	examiner? 1 ☐ Yes 2X No	Hospital: 1 🗌 Inpatient 2 🛭	☐ ER/Outpatient	3□ DOA Othe	er: 4 🗆 Nursing Ho		make a	☐Other (Spec	city)
io the Funeral briector: Affer this certificate has completely filled in by the funeral director, page 2	Certification:	27. Manner of Death 1 X Natural 2 \(\text{Accident} \) Accident	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury Work	y at ⟨? Yes 2 □ No	28d. Describe ho			
d in by t	Sertific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, stree sity)	et, factory, office		28f. Location (St City or Town	reet and . n, State)	Number or Ru	ıral Route Number
ro the Funeral completely filled	Medical (29a. Certifier (Check only one) Certifying Phy	sician: To the best of my kniner: On the basis of examin	nowledge, death on ation and/or inve	occurred at the timestigation, in my op	ne, date and place, pinion, death occurr	and due to the ca ed at the time, da	ause(s) a ate and p	nd manner as lace, and due	stated. to the cause(s)
dwo	Me	29b. Signature and title of continen	1 20.		29c. License	number	2	9d. Date	signed (Monti	h, Dey, Year)
- 0	q I	- WHILL &	Chus M		MD329	28	T	HMF .	4, 200	<i>l</i> .
/		C Y Y PP			HUJZJ	20	J	ONE	4, 200	4

			1 - State of Maryland / Department of Health and Certificate of Death		ene 2004 18185
	Physic		A CONTRACTOR OF THE PROPERTY O	2. Date of Death Month	Day Year OO M M
	/Medi Examii		4a. Facility Name (If not institution, give street and number) Shady Grout Abyrung Hoghtma Cockyus Cockyus		4c. County of Death MONT GOMEN
	Funeral Director		5. Social Security Number 428-35-2234 Usual Residence of Decedent 6. Sex 1 M 2 F 26 7. Age (In yrs. last birthday) 26 Yrs. If Under 1 Year If Under 24 Hrs Months Days Hours Min		
	within 72 hours after death with the Maryland ane. then "neturel", or Items 23e or 28e-f show the Medical Eventrett mat be notified at	Director	10a. State 10b. County 10c. City, Town or Location Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code		10d. Inside City Limits 1 X Yes 2 □ No g. Citizen of What Country?
9800	s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. Item 27 Is marked other then "neturel", or Items 23e or 28e-f show other treumetic event, the Medical Exercites that Le muffical at	d by Funerai	If Yes, Give 1 ☐ Yes 2 ☒ No Specify:		United States 14. Race - American Indian, Black, White, etc. Specify: White
121215-0036	filed within 72 h Hygiene. Ither then "netu	Completed		orking	Towing
Maryland	2 should be filed withir n and Mental Hygiene. Is marked other then reumetic event, the Mental Reumetic event, the Mental contents and the mental contents are mental contents.	To Be	Jurney R. McKibben, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ri		City or Town, State, Zip Code)
Baltimore, I	00			Date 20	c. Location - City or Town, State Silver Spring, MD
Ball	permit. Page Department Importent: I any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute Fun 1040 Rockville Pik 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia.	e; Rockvil	lle, MD 20852
8760,	Medical Examiner hysician and the buriat-transit	dicai Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the cause (Disease or injury that initiated events resulting in death) Last EUSCOTATION OF MODING Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Interval Between Onset and Death
.O. Box 68	ne death certific the attending p thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ □ Unknown		23d. Date of delivery Month Day Year
<u>α</u>	The law requires that the tas been signed by bage 2 should be detact	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
Vital Records,		e Completed	OF Man and referred to made at	24a. Was an autopsy performe 1 Yes 2	
Division of Vi	Attending Physic: r death. sctor: After this ce by the funeral direc	Certification; To Bo	examiner? 1 X Yes 2 No Hospital: 1 Inpatient 2 XER/Outpatient 3 DOA Other: 4 Nursing H	28d. Describe how a AUTO CW 28f. Location (Stree	13H 24TO FEV CT
D	Hospite 4 hours Funerel ety filled	Medicai Cert		e, and due to the caus	many (shiThensoule) Mo
)	To the within 2 To the complete	Med	29b. Signature and title of certifier One One 29c. License number DIS 236	29d.	Date signed (Month, Day, Year)
_	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chart T. MARGOLS, MD 11125 ROCKING PIKE, LOC	ikvius, Mo	20852
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 9 2004		

		epartment of Health and M Certificate of Death		ne No.2004	18186
Physician /Medical	wabten bougeas morrow		Date of Death Month	Day Year 5 205 Ч	3. Time of Death 5:13 P M
Examiner	4a. Facility Name (If not institution, give street and number) Stella Maris @ Mercy 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd)	4b. City, Town, or Location of Death Baltimore ay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	4c. County of Death N/A 9. Birtho	place (State or Foreign
Director	212-01-2536 1		8. Date of Birth (Month, Day, Ye April 2, 1		ykand
in the Marylar or 28a-1 show mouthled at	,	Baltimore 101. Zip Code	100	Citizen of What Cour	10d. Inside City Limits 1 X Yes 2 □ No
ath with sate with with with a same of the sate of the	9 South Ellwood Avenue	21224		U.S.A.	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-1 show amy injury or other traumatic event, the Madical Excition trainst by nutilised an once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never in U.S. Armed Forces? 1 Never Neuron Dates: WW II	 Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto □ Yes 2 No Specify: 	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: White	etc.
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. To marked other than "natural; or traumatic event, the Medical Exercitation of To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10th Grade 16a. Decedent's Education (G	ocedent's Usual Occupation live kind of work done during most of worki e. DO NOT use retired) etter Carrier	ng	S Post Off	
aryland 2 should be filed nd Mental Hyg or marked other umatic event, 1 To Be Co	Leon Morrow	18. Mother's Name Nell	(First, Middle, Maid Dempsey	den Surname)	
More, Mar. Pages 1 and 2 sho ent of Heelth and nt: if them 27 1sm.	Mrs. Mary E. Morrow (wife) 9.	ailing Address (Street and Number or Rura South Ellwood Ave.,	Baltimor		2.4
Baltimore, semit Pages 1 a Seperanent of Hee my my injury or other boxe.	TADERIA 2 OF TRANSPORT STATE OF THE PROPERTY O	crematory or other place)	2004 Ba	ltimore. N	Maruland
Bal Dermi Impo Impo any ir	23a. Part1. Enter the disease, or complications that caused the death. Do not	9705 Belair Rd., 1	Baltimore.	, MD 21236	Approximate
by Sicion and when boursel-transit the burial-transit dical Examiner	Immediate Cause (Final disease or condition resulting in death) a				Interval Between Onset and Death
Division of Vital Records, P.O. Box 6i To the Hospital or Attending Physician: The law requires that the death certific within 24 hours elter death. To the Funeral Director: After this certificate has been signed by the ettending p completely filled in by the funeral director, page 2 should be detached for use as: Medical Certification; To Be Completed by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ry Day Year
cords, P. w requires that the been signed by should be deta	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	e cause of death? ably 4 Unknown
f Vital Record ysician: The law requir is certificate has been si director, page 2 should To Be Completed			24a. Was an autopsy performed 1 Yes 2	2 prior to con death?	osy findings available inplation of cause of
Sion of Vital sending Physician: 1 learth. the tuneral director, p	25. Was case referred to medical examiner? 1	of 28c. Injury at 2 Work?	101	6€Other (Specify	hospice
Division c tal or Attending P is eliter death. all Director: Affect led in by the funera Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No street, factory, office 2	8f. Location (Street City or Town, Sta	and Number or Rural ate)	Route Number,
To the Hospital within 24 hours to the Funeral I completely filled	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	path occurred at the time, date and place, a investigation, in my opinion, death occurre	nd due to the cause od at the time, date a	e(s) and manner as sta and place, and due to	ated. the cause(s)
T With the contract of the con	29b. Signature and title of certifier	29c. License number		Date signed (Month, D	,
6	30. Name and address of person who completed cause of death (Item 23a) Typ Marvin 5 Feldman 301 57		, , , , , , ,	nd 212	^7
State Registrar	31. Date filed (Month, Day, Year) JUN 0 9 2004 32, Registrar's Signature	long.	ATRUI C Y	ruce Cic	N.C.

CALVIN MOONEY

		State of Maryland / Dep 1- State Registrar Ce		lental Hygie	_
Dhysia	ion	Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death
Physic /Medi		Calvin H. Mooney		June	5, 2004 5:15 P M
Exami	ner	4a. Facility Name (If not institution, give street and number) Stella Maris	4b. City, Town, or Location of Death Timonium		4c. County of Death Baltimore
Funeral Director		5. Social Security Number 216-14-4378 Cusual Residence of Decedent 6. Sex 1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y) JULY 9,	ear) 9. Birthplace (State or Foreign Country) 1923 Maryland
Maryland 8-f show	ctor	10a. State 10b. County 10c. City, Town or L. Maryland Baltimore	ocation Baltimore		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
h with the 23a or 28 at be no	al Director	10e. Street and Number 4116 Lochcarrow Road	10f. Zip Code 21236	10g	Citizen of What Country?
036 ours after deal rall, or Itema ?	by Funeral	1 Never Married 2 N Married 1 N Yes 2 No	Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. th's marked other than "natural", or Itema 23a or 28a-f show traumatic event, the Mudical Evans ratural by notified at	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation skind of work done during most of work DO NOT use retired) Supervisor	ng	b. Kind of Business/Industry Defense
/land uld be file Mental Hy urked othe	To Be C	17. Father's Name (First, Middle, Last) Hillary Mooney		Mooney (:	iden Sumame) Swrname Unknown)
Mar d 2 sho th and 7 is m		Mr. Gordon Spangler (of Atty) 4100 20a. Method of Disposition 1	matory or other place)	Baltimor	e, MD 21236 c. Location - City or Town, Slate
Baltimore, I permit. Pages 1 and Department of Heall Important: If Item 2 any injury or other once.		4 □ Donation 5 🗓 Other (Specify) Entombment Gardens 21. Signature of Funeral Service Licenses 22.	of Faith Maus 7/8/ 2. Name and Address of Facility Sch 9705 Belair Rd., E	rimunek Fi	uneral Homes
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. DEMENTIA Due to (or as a consequence of):			
68760, ificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usaase or might) that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
Hecords, P.O. Box 68 The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as th	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
COLdS, P. w requires that is been signed be should be deta	b	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		co use contribute to the cause of death?
	Completed			24a. Was an autopsy performed 1 Yes 2	
ysician: Tysician: o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	26. Place of Death	(Check only one) ne 5 ☐ Residence	e 6 X Other (Specify) HOSPICE	
On Of oding Phy th. : After this tuneral d	tlon; T	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 1 Accident investigation		28d. Describe how i	//
DIVISION OF VITA Hospital or Attending Physician: A hours after death. Funeral Director: After this certific tely filled in by the tuneral director,	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stream building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the basis of examination and/or in and manner stated.	h occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the caus and at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the within 2 To the complete	W	29b. Signature and title of certifier	29c. License number D 4 3725		Date signed (Month, Day, Year)
THY		30. Name and address of person who completed cause of death (Item 23a) (Type, DR. TARIQ MAHMOOD 2300 DULANEY VAL	·	MD 2109	3
St Regist	ate rar	21 Date filed (Month Day York)	Sparis		
DHMH 17 Pay 1/	_	, , , , , , , , , , , , , , , , , , , ,	/		

4			Please	State of Maryla				•	_	.
			1 - For State Registrar	State of Maryla		rtificate of			200	11. 1910
			Decedent's Name (First, Middle, La	ist)			Dodin	2. Date of Dea	ith	3. Time of Death
ا ا	Physici /Medi		RONALD			N	ESS	JUNE	Day Ye	
2	Examir		4a, Easility Name (If not institution, gir	e street and number)		4b. City, Town, o	or Location of Death		4c. County of D	
*			The Johns He	policies Hospiti	rah	Balto	more e	City	N/A	A
	uneral		5. Social Security Number 6.6		rs. last birthday) 53 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Minth, Day June 26	Year) 9.	Birthplace (State or Foreign Country)
	irector		Usual Residence of Decedent	X	J. 118.			June 26	, 1950	VID. "
yland	Mon		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
Mar	in Diagram	to	MD Baltimo	re 1	Dundalk					1 ☐ Yes 2 🔀 No
# #	or 28	by Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
w the	23a	ra I	200 South Woodwel.	l Avenue		2122	22		USA	
ер и	Tema F	une	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
rs aft	0 2	oy F	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify:	White
within 72 hours after death with the Maryland ene.	if item 27 is marked other than "natural", or itema 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at		15. Decedent's E	ducation	16a. Dece	dent's Usual Occur	pation	1	16b. Kind of Busine	ss/Industry
nd 2 should be filed within 72 hours aff	Med	pie	(Specify only highest gr. Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	pation during most of world)	king		,
filed wit	= =	Completed	12 years		Shipk	ouilder			Curtis Ba	y Ship Yard
be it	d oth	Be	17. Father's Name (First, Middle, Last George Ness)					Maiden Sumame)	
should be	narke	10					Eleanor			
d 2 sh	7 is n traun		19a. Informant's Name/Relationship (Deborah Ness						r, City or Town, State	
1 and Health	ther		20a. Method of Disposition	wife 20b	. Place of Dispo	sition (Name of			dalk, Md. 2	
ages ont of	y or o		1 N Burial 2 □ Cremation 3 □ 1 Other (Specie	Removal from State	cemetery, crer	natory or other pla	tery June :			
permit. Pages 1 ar	Important: If itam 2 eny injury or other once.	1	21. Signature of Funeral Service Lice			_			Rosedale,	
Pe G	eny ir		the Atomic	(onnol	XU 71	nnelly F	uneral Ho	me Of Du	ındalk,P.A ındalk,Md.	. 21222
	e e		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused the de	eath. On not ent	er the mode of dyir	ng, such as cardiac	or respiratory arr	est,	Approximate
Phy	sician		Immediate Cause (Final disease or condition	. FULMINA			FAILU			Interval Between Onset and Death
/M	edical		resulting in death)	Due to (or as a cons		CIMIL	+H120	KC		& DAYS
Exa	miner		Sequentially list conditions	. HEPATI	TIS	C				YEARS
9	sit	iner	Sequentially list conditions, 1 any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):					
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The law requires that the death certificate	attending physical for use as the b	ed c		_ d						-
eath certi	nding use a	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg	gnancy				23d. Date of d	delivery
death	e atte	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	etal death 3∟ f death 5□	JEctopic pregnancy Other (specify) _	/		Month	Day Year
hat the d	by the	hys	9 Unknown	9□ Unknown						
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aw	2 3	Completed						24a. Was a autops	n 24b. Were	autopsy findings available o completion of cause of
The	page	Cou						perform	ned? death	?
cian	s certificate has b lirector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		Tai		h (Check only on	θ)	
Phye	this (- To	1 ☐ Yes 2 🗙 No 27. Manner of Death	1 Dinpatient 2			4 Unursing Ho		nce 6 Other (St	pecify)
ding h.	After	tion	1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1	yat k? Yes 2 □ No	28d. Describe no	w injury occurred	
or Attending Physician: The law requires t after death.	Director: in by the	fica	3 Suicide 6 Could not b	e Ogo Blace of Injury At	home, farm, stre		163 2 110	28f. Location (St	reet and Number or	Rural Route Number,
al or	f Dire	Certification:	4 ☐ Homicide determined	building, etc. (Spec	cify)			City or Town	, State)	Tale Front Grant Sor,
pepita	unera y fille		29a. Certifier 1 Certifying Ph	nysicien: To the best of my ki	nowledge, death	occurred at the tin	ne, date and place,	and due to the ca	ause(s) and manner	as stated.
To the Hoepital or within 24 hours afte	To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medicai	one)	niner: On the basis of examinant manner stated.	nation and/or inv	estigation, in my o	pinion, death occur	red at the time, da	ate and place, and di	ue to the cause(s)
To t	Com	Σ	29b. Signature and title of certifier	1		29c. Licens		29	9d. Date signed (Moi	nth, Day, Year)
(1		Sara Ha	Lutt, M.D.			5-000		ONE 5	, 2004
	D		30. Name and address of person who				- 20			210
100	Cto		S'ARA HAZLETT 31. Date filed (Month, Day, Year)	JOHNS HOPK 32. Registrar's Sign	CINS HO	SPITAL	BALTIME	RE, MA	RYLAND	21205
	Sta Registr		IIIN o	A Di	lo	1. 42	-			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2004 Nash Sr. Ronald /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Mercy Stella Maris Hospice 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days 1 🛛 M 2 🗆 F Yrs. MD 212-42-7421 Usual Residence of Decedent Director 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County ral', or Items 23a or 28a-f show Examiner must be rectified at 1 ☐ Yes 2X No Catonsville MD Baltimore Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 U.S.A. 1329 Willow Spring Road Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 3 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: þ 3 ☐ Widowed 4 ☐ Vivorced Black "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Home Decorator 12th grade NA18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Josephine C. Waters John T. Nash Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21228 19a. Informant's Name/Relationship (Type, Print) 27 1329 Willow Spring Road, Catonsville, Md Vertel Nash-Ex-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages to Department of Himportant: If ite any injury or ot once. 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State Metro Crematory Inc. 6/9/04 Baltimore, Maryland ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
March F/H West 21. Signatura of Funeral Service Licensee 4300 Wabash Ave, Baltimore Md 21215 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final prosta **Physician** disease or condition resulting in death) /Medical Due to (or as a co equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and the burial-transit The law requires that the death certificate be executed Exam Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) the Dec signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 20 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 🗌 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence S Other (Specify) 2 1 ☐ Yes 2 No this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral t

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2004 40854

State Registrar

32 Registrar's Signature JUN 0 9 2004

301

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

se Dera

Ri

31. Date filed (Month, Day, Year)

Sports

Himore

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	1 - For State Registrar AMEND IT	State of Ma EM #8 PER FH	G832 6/企	Afficate of Death		19. No.2004	18190					
	Physici	an	1. Decedent's Name (First, Middle	le, Last)			2. Date of Death	n Day Year_	3. Time of Death					
	/Medic		Mary		abeth	Parker	the	6 2004	1:05 AM					
	Examin	er	4a. Facility Name (If not institutio			4b. City, Town, or Location of Deatl	h	4c. County of Death						
			5t. Agnes 5. Social Security Number	1-calthcare	e (In yrs. last birthday)	Baltmore If Under 1 Year If Under 24 Hrs.	8 Date of Birth	0-22-119 Birthe	place /State or Foreign					
	Funeral Director		214-22-1540 Usual Residence of Decedent	1□ M 2 X 2 X F	92 Yrs.	Months Days Hours Min.	(Month, Day, 04 16	0-22-119. Birthp Year) Cour	Md					
	land		10a. State 10b. County	· · · · · · · · · · · · · · · · · · ·	10c. City, Town or Lo	ocation		1	Od. Inside City Limits					
	Mary -f sh	tor	MD N	Δ	Baltimor	·e			1 X Yes 2 □ No					
	r 28a	Director	10e. Street and Number	**	2445262	10f. Zip Code	10	g. Citizen of What Cour	ntry?					
	th with		2423 West La	favette Av	e	21216		U.S.A.						
	ems ems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Americ Black, White,						
21215-0036	s within 72 hours after death with the Maryland Jiene. r than "naturel", or Items 23a or 28a-1 show The Madical Examiliar roust be muffind at	þ	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	ried 1 ☐ Yes 2 🔀	No	1 ☐ Yes 2X No Specify:	, , , , , , , , , , , , ,	Specify:	lack					
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121			12th grade	na	T	eacher's Aid		Baltimore	City					
Maryland	d ta b	Be	17. Father's Name (First, Middle,				ne (First, Middle, M	•						
ž	should bent and Ment markac	ဥ	Samuel O. Ha 19a. Informant's Name/Relations		10h Mailir	Frances ng Address (Street and Number or Ru	R. Enn		Codel					
Ma	d 2 a a a a a a a a a a a a a a a a a a				Facilities	THOUGHT AND THE	201 12 22	0.6	=27					
ē,	s 1 and 2 f Health item 27 I		Delores Kerr 20a. Method of Disposition	-	20b. Place of Dispo	Monticello Ro sition (Name of matory or other place)		timore Mo Oc. Location - City or To						
9	8° = ₽		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5	3 ☐Removal from State Specify)		!	6/11/0	A Ambartan	Ma					
Baltimore,	erth orts inju		21. Signature of Funeral Service			Memorial Park Name and Address of Facility Tarch F/H West	6/11/0	4 Arbutus	, MG					
ä	Depermine any in once.		1 Dum	SK	etc 4	arch F/H West 300 Wabash Ave	. Balti	more Md	21215					
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	Physician		Immediate Cause (Final disease or condition Atherical Cauchts California So Jams											
	/Medical		resulting in death)	Due to (or as	a consequence of):	2, 40-100000	, , , ,	, , , , , , , , , , , , , , , , , , , ,						
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687	ficate physis the	edlcal		d.										
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	death e atte	icla	in the past 12 months?	4☐Pregnant at		Ectopic pregnancy Other (specify)		Month	Day Year					
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	es the	by F	Part II. Other significant conditi	ions contributing to death b	out not resulting in the u	nderlying cause given in Part I.		acco use contribute to th						
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Records,	law r las be	Completed	112he11	mers 10	1e men 1	f U	24a. Was an autopsy	prior to cor	psy findings available inpletion of cause of					
<u>=</u>		Con					perform 1 ☐ Yes 2	ed? death? No 1 ☐ Yes	≥ No					
Vital	ician: certific rector,	Be	25. Was case referred to medica examiner?	Hospital:			ath (Check only one)						
of	Phys this al dii	2	1 N Yes 2 No 27. Manner of Death	1 🗆 Inpatie			ome 5 Resider	nce 6 Other (Specify	")					
no	ing After une	tlon	1 Natural 5 ☐ Pendi	28a. Date of Inju ng (Month, Da igation	y Year) 28b. Time of Injury	f 28c. Injury at Work? M 1 □ Yes 2 □ No	200. 0630106 1104	w injury occurred						
Division	be ber	flca	3 ☐ Suicide 6 ☐ Could	not be One Bless of Ini	ury - At home, farm, str		28f. Location (Stre	eet and Number or Rura	I Route Number.					
<u>S</u>	after after Dire d in b	Certification:	4 Homicide		c. (Specify)		City or Town,	State)						
	To the Hospitel or Atti within 24 hours after de To the Funerel Direct completely filled in by t	Medical (29a. Certifier 1 Certifyi (Check only one) 1 Medical	ng Physician: To the best Examiner: On the basis o and manner st	f examination and/or in	n occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the car rred at the time, da	use(s) and manner as st te and place, and due to	ated. the cause(s)					
	To the within To the complex	Me	29b. Signature and title of certific			29c. License number	Target .	d Date signed (Month, i	Day, Year)					
	1.		· //W/	new	145	p0027315]	unc 6, i	2004					
	10		30. Name and address of person	who completed cause of	leath (Item 23a) (Type,		- 1	. 1						
			St. Hynes F	tospital/	1501 AM	we 19C	rrya	en novy	MO					
	Sta Registr		31. Date filed (Month, Day, Year		ar's Signature	Ann V.	/	/						

Parker, Mary X

			1 - For State Registrar	State of Mar		artment of I		nd Mental Hy	rgiene2 0	04 18191
	Physic		1. Decedent's Name (First, Middle, Last)	ENDER	2			2. Date of De Month	aath Day	Year 730 P M
	/Medi Examir		4a. Facility Name (If not institution, give s	reet and number)	_	4b. City, Town,			4c. County	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (/	n yrs. last birthday) 2 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bir (Month, Date of Bir 1)	th ay, Year) 5 12	Birthplace (State or Foreign Country) NC
	/land low		Usual Residence of Decedent 10a. State 10b. County	10	0c. City, Town or La	cation				10d. Inside City Limits
	e Mary Sa-f sh Tiffied	ctor	MD NA		Baltimo	re				1 ☐ Yes 2 🙀 No
	with th	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Country?
	death ms 23	neral	11.00 Pennsylvani	2. Was Decedent Eve	er in U.S. 13. \	Was Decedent of I	1201 Hispanic Origin	? (Specify Yes or No	U.S.	e - American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23e or 28e-f show many injury or other traumatic event; the Medical Exerting must be notified at once.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ② Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2X X o If Yes, Give Year or Dates;		f Yes, specify Cub I □ Yes X XNo	an, Mexican, F	uerto Rican, etc.)		k, White, etc.
5-0036	72 hou	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	ient's Usual Occup kind of work done	pation	working	16b. Kind of Bu	usiness/Industry
2121	within ene.	mpi	Elementary/Secondary (0-12) 7th grade	College (1-4or 5+)	life. L	Do NOT use retire Domesti	d)	g	Dani	****
	be filed tal Hygid d othar evant, t	Be Co	17. Father's Name (First, Middle, Last)	na		Jomesci		Name (First, Middle,		.vate ^(a) Unknown
Maryland	should be ind Mental markad o	To E	Charlie Grant							
Mai	and 2 sho saith and n 27 la m		19a. Informant's Name/Relationship (Typ							State, Zip Code) 21201
ore,	of Health of Health if itam 27 or othar tra		Penry Cooper-Son 20a. Method of Disposition Description Cooper-Son 20a. Method of Disposition Cooper-Son 20a. Method of Disposition Cooper-Son	;	20b. Place of Dispo:	Pennsy sition (Name of natory or other pla		Date A	20c. Location -	Balto, Md City or Town, State
Baltimore,	permit. Pages Department of I Important: If it, any injury or o		`4 Donation 5 □ Other (Specify)					11/04	Baltim	ore, Md
Bai	permit. Departr Imports any inju		21. Signature of Funeral Service License	- Thomas	. / Ma	Name and Addre	H West			
	*		23a. Part Per the disease, or complice shock, or heart failure. List only one	ations that caused the	death. Do not ente	or the mode of dyir	ng, such as car	diac or respiratory as	rest,	Approximate Interval Between
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	p =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):	1 / 1	0 100			i wait
	be exacuted sician and burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a co	onsequence of):					
68760,	icate be exacuted physician and s the burial-transit	edicai E	d.							
~	n cartifica ending ph use as th		IF FEMALE:	If you system of a						
Box	death cartif s attending d for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	b. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)	′		23d. Date Mon	o of delivery ith Day Year
P.0	at the de d by the a stached	Phys	9 Unknown	9□ Unknown						
of Vital Records,	The law requires that the death cartif te has been signed by the attending bage 2 should be detached for use a	by	Part II. Other significant conditions cont	in the ch		derlying cause giv	en in Part I.			bute to the cause of death? 3 Probably 4 Denknown
eco	e law re has bed je 2 sho	Completed	<u>'</u>					24a. Was autop	sy pi	Vere autopsy findings available rior to completion of cause of
alB		e Cor	25. Was case referred to medical					perfor 1 ☐ Yes	med? de	eath? □ Yes 2□ No
f Vii	Ø .2 .5	To Be	examiner?	spital:	2 ER/Outpatient	3□ DOA Oth		Death <i>(Check only or</i> g Home 5 ☐ Resid		r (Specify)
	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	28c. Injun Wor	y at k?		ow injury occurre	
Division	deat deat ctor: / the	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	At home, farm, stre		Yes 2 □ No	28f. Location (S	treet and Numbe	r or Rural Route Number,
Ö	ital or A irs after ral Dira led in by	Certification:	- I Homicide	building, etc. (S	ipecify)			City or Tow	n, State)	
	To the Hospital of within 24 hours af To the Funaral D completely filled in	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	rian: To the best of m r: On the basis of exa and manner stated.	y knowledge, death amination and/or inve	occurred at the tin estigation, in my o	ne, date and pl pinion, death o	ace, and due to the occurred at the time, o	ause(s) and man late and place, ar	ner as stated. nd due to the cause(s)
	withi To th	ž	29b. Signature and title of certifier	- A)	29c. License				(Month, Day, Year)
,	cx		30. Name and address of person who com	pleted cause of death	(Item 23a) (Type F	-	-434		SUNE	1,2004
	Α,	/1=2	SOSEPH COSTV	1, 10	301 5		- PLAC	E BAC	TIMORE	50215 ON,
	Sta Registra	_	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	for de				

			1 - For State Registrar	State of	Marylan		artmen rtificat					giene Reg. No. 2	04	18192	
	Physici /Medio		1. Decedent's Name (First, Middle, Ameil J. Ruffir								2. Date of De Month June 6,	Day	Year	3. Time of Death 11:30am ^M	
	Examir		4a. Facility Name (If not institution, 1630 Fast Fort Av	-	oer)		4b. City,		Location o	Mary.	Land	4c. Count	4c. County of Death N/A		
	Funeral Director		214-22-6588	6. Sex 7 1 52 M 2□ F	. Age (In yrs. 75	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da August	12,1928	9. Birthp Cour	place (State or Foreign htry) MD	
	Maryland In show	tor	Usual Residence of Decedent 10a, State 10b, County MD	N/A	10c. Cit	y, Town or Lo	ocation	I	altim	ore C	ity		1	0d. Inside City Limits ▼XYes 2 □ No	
	3e or 28s	i Director	10e. Street and Number 1449 Richardson S	træt			10f. Zip		21230			10g. Citizen of Unit	What Cour red Sta		
9800	s 1 and 2 should be filed within 72 hours after death with the Maryland of Heelth and Mental Hygiene, then "neture", or Items 23e or 28e-f show item 27 is marked other than "neture", or Items 23e or 28e-f show other treumatic event, it is Madical Examiner mark be notified at	d by Funerai	11. Marital Status 1 □ Never Married 2 □ Marrie 3 🛣 Widowed 4 □ Divorced	12. Was Deced Armed Force 1XX es 2 If Yes, Give Year or Date	es? □No Nat	v	Was Deced If Yes, spec		ispanic Ori n, Mexicar Specify:	gin? (Spe n, Puerto	ocify Yes or No Rican, etc.)	- 14. Rai Bla Specif	ce - Americ ck, White, fy: Wh		
21215-0036	within 72 h iene. • than "netu Ite Medical	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4	for 5+)	(Give life.	dent's Usua kind of wo DO NOT us uty Sn	rk done d se retired	<i>luring m</i> os ')	t of worki	ng	16b. Kind of Business/Industry Public Service			
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	and 2 sho leelth and I m 27 Is me		19a. Informant's Name/Relationsh Michele Annette Kn		ter		-				Route Number Marylan	ar, City or Town	, State, Zip	Code)	
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition 1 Strain 2 Cremation 4 Donation 5 Other (Sp			Place of Dispo emetery, crei LE Hill	natory`or o	ther plac	June		oo4	20c. Location Baltim	-		
Balt	permit. Departr Importe any inji		21. Signature of Funeral Survice L	icensee Victor 1	P. Doda,		Name and less 501 Eas	d Addres L. S st Fo	s of Facilit tevens rt Ave	Fune	ral Home, Baltimore	Inc. MD 2123	0		
8760,	The law requires that the death certificate be executed with the aspen signed by the attending physician and wigher coage 2 should be detached for use as the buriat-transit or as as the buriat-transit.	dicai Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if the cause (Disease or injury that initiated events resulting in death) Last	a	ch line.	uence of):						ance		Interval Batween Onset and Death	
P.O. Box 6	that the death certificed by the attending of detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ☐ Feta nt at time of d	Idéath 3□	Ectopic pr Other (sp						le of delive	ory Day Year	
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Division of Vi	ling P	Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n	ation	Injury Day Year)	ER/Outpatier 28b. Time of Injury	M 2	8c. Injury Work 1 🗀 Y	er: 4 □ Nu	rsing Hor	ne 5 Resid	lence 6 Oth		1700,30	
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	To the Hospitel within 24 hours a To the Funerel I completely filled	Medicai	(Check only 2 Medical E	xaminer: On the bas and manne	is of examina	tion and/or in	vestigation,	in my op	oinion, dea	th occurre	ed at the time,	date and place,	and due to	the cause(s)	
)	To To To Com	Σ	29b. Signature and title of certifier M/A	Perlem	mo		0		-78			29d. Date signe	2,20	04	
	. Sta	ite	30. Name and address of person v 31. Date filed (Month, Day, Year)	Kina	of death (Item	300	Print)	h H	inuve	· N	next R	Saltimor	4, Mus	, land 21225	
	Registi	ar	HIN 0 9 2004	Dener	~ /	1 sty	pouls								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 17 PER FH G832 Certificate of Death Reg. No. 1 - For State Registrar AMEND ITEM #17 PER FH G832 Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Ray Year Margaret 01 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Deeth 1.5 KINS $\mathcal{B}a$ HOP Baltimore
If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) **Funeral** Days Months 1□M 2XF Hours Min. Yrs. NIA Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumaild event, the Macdical Examinating as 1 Yes 2 No Directo BERMUDA BERMUDA 10e. Street and Number 10g. Citizen of What Country? 115P TEIGHTS BERMUDA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ If Yes, Give Year or Dates: Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Macie. Elementary/Secondary (0-12) College (1-4or 5+) 7 THGRADE HEADWAY HAIR JALON BEAUTIC 17. Father's Name (First, Middle, Last) RODRIGUES 18. Mother's Name (First, Middle, Maiden Sumame), Be JIL 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELAINE KELL POKIOK CRESCENT (DAUGHTER SMITHS DERMUARF105 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) CALVARY R. C. CEMETERYOG-11-04 FEMBROKE BERMUDA 22. Name and Address of Figility BROWN TR. FUNERAL HOME
JOSEPHH. BROWN TR. FUNERAL HOME 21. Sign ture of Funeral Service Licensee 3a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

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Approx Approximate Interval Between Onset and Death Immediate Cause (Final I schenic **Physician** Cardiomyorathy Days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physiclan/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 menths? 3 Ectopic pregnancy Month 4□Pregnant at time of death P.O. 5 Other (specify) ed by the a 9□ Unknown 9 🗆 Unknown signed t d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ hyperchologyrulemin 1 Yes 2 No 3 Probably 4 Unknown Be Completed peeu s certificate has b Irrector, page 2 si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No Division of Vital 2 🔀 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 1 ☐ Yes 2 No Certification: To Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending within 24 hours after death.

To the Funeral Director; A c. mpletely filled in by the fu investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Medical Poctor RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 NOKTH WOLFE JUKDAN PRUTKIN, *CKEE BALTEMORE PROFITATIONS

Registrar

State

31. Date filed (Month, Day, Year)

JUN 0 9 2004

32. Registrar's Signature

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	_	For Stata Registrar			Cer	tificate of	Death		Reg. No	o	1010
hysician	_	. Decedent's Name (First, Middle, I		Pac	mucc	on		2. Date of Dea	Da	ay Year	3. Time of Death
/Medical			Elizabeth	Ras	muss		or Location of Death			c. County of Death	4:20a M
xaminer	4.	a. Facility Name (If not institution, g								Baltimor	~
	5	Gilcrist Cent Social Security Number 6		(In yrs. las	t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birthi	Dlace (State or Foreig
neral ector	1	219-05-5815 Juan Residence of Decedent	1□ M 2□ X F	83	Yrs.	Months Days	Hours Min.	April	y, Year 15	r) Cou.	aryland
M II	-	0a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
outilied at		MD Balt	imore				Essex				1 ☐ Yes 2 ☑ No
Director	1	Oe. Street and Number	as Road			10f. Zip Code	1221		•	itizen of What Cou	ntry?
once. To Be Completed by Funeral Director	1	1. Marital Status 1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 □ Yes 2 N If Yes. Give			1	dispanic Origin? (Si an, Mexican, Puerto	pecify Yes or No- pecify Rican, etc.)		14. Race - Ameri Black, White, Specify: Whi	etc.
d by	į -	3 ∰Widowed 4 ☐ Divorced	Year or Dates:		16a Dassa	Institution Consu	tion		106 1	Kind of Business/In	
Completed		15. Decedent's (Specify only highest)			(Give	lent's Usual Occu kind of work done OO NOT use retire	during most of wor d)	king			
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i S	1	8th 17. Father's Name (First, Middle, La	st)				18. Mother's Nan	ne (First, Middle,	Maide	n Sumame)	
o Be	i	Frederick V	Junder				Cathe	rine Ca	arn	ev	
To		19a. Informant's Name/Relationship		1	19b. Mailir	a Address (Stree	and Number or Ru		-		code)
		Richard Rasmy					afras R				
O C C C C C C C C C C C C C C C C C C C	2	20a. Method of Disposition 1∑ Burial 2 ☐ Cremation 3	☐Removal from State	20b. Plac	ce of Dispo	sition (Name of natory or other pla	сө)	Date	20c. L	Location - City or To	own, State
JCe lland		`4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lic	17.7	10		. Name and Addre		onnelly	/Fu	neralHo:	meofEsse
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Examiner		that initiated events	c								
EX EX		resulting in death) Last	Due to (or as a	conseque	nce of):						
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as the burial-transit	-	IE EENALE.									
		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth			Ectopic pregnanc	у			23d. Date of deliv	
detached for use		in the past 12 months? 1 — Yes 2 M No	4☐Pregnant at t 9☐ Unknown			Other (specify)				Month	Day Year
, h	-	9 Unknown	30 ONATOWN								-
<u>o</u> <u>u</u>	, F	Part II. Other significant condition	s contributing to death bu	it not resulti	ing in the ui	nderlying cause gr	ven in Part I.	23e. Did to	obacco	use contribute to t	
2								101	/es 2	2 ☐ No 3 ☐ Prol	bably 4 Unknow
8 6	3 -							24a. Was autop		24b. Were auto	opsy findings availab impletion of cause of
<u>مَ</u> ۾	-							perfo	rmed?	death?	
<u>مَ</u> ۾	-						26. Place of Dea	th (Check only o			4
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			For State Registrar	State of M	Marylan		artment rtificate			and M		Reg. No.	004	18195
	Physici /Medic		1. Decedent's Name (First, Middle VIOLET, T		CHEI	N					JUNE	Day	Zooy	3. Time of Death
	Examin	er	4a. Facility Name (If not institution			stem			Location o		n		ty of Death	RECITY
	C		Univ of Maryla 5. Social Security Number			last birthday)	If Under	1 Year	CRE If Under	24 Hrs.	8. Date of Birt	th		ace (Stete or Foreign
A.	Funeral Director		216-36-0648	1□M XX F	65	Yrs.	Months	Days	Hours	Min.	Month, De May 25	, Yeer) , 1939	Count	MD
	D .		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10	d. Inside City Limits
	Maryia f sho	-0	MD N/A			.,,		Ba 1	timo	re C	ity			1. Yes 2 No
	r 28a-	rect	10e. Street and Number				10f. Zip			_		10g. Citizen of	f What Count	ry?
	23a o	ai D	1626 Belt Str	eet					2123				JSA	
	er des Items	Funeral Director	11. Marital Status	12. Was Decede Armed Force	s?	.S. 13.	Was Deced If Yes, spec	ent of Hi	spanic Ori n, Mexican	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	- 14. Ra	ace - America ack, White, e	
39	urs aft	by F	1 ☐ Never Married 3 ☐ Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2] If Yes, Give Year or Date			1 ☐ Yes 2	₩	Specify:			Spec	ify: W	nite
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f show I.a Medical Examiner must be notified at	Completed	15. Deceden	t's Education at grade completed)		(Give	dent's Usua kind of wor	k done d	turing most	t of worki	ing	16b. Kind of	Business/Ind	ustry
121	within ne. than	mple	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life.	DO NOT us Hom	e retired emak				_	rm Hor	
9	filed v Hygie other f		12 17. Father's Name (First, Middle,	Last)		1	11011	CILICIA		er's Name	(First, Middle,		Own Hor	ile
an	Mental Mental rked o	To Be	Ernest L. S	awyer							Violet	Victor	ia Huf	f
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, if a Medical Examiner must be notified at		19a. Informant's Name/Relations				•				I Route Numbe			Code)
	1 and Health tem 27 other tr	1 8	Arnold Schein 20a. Method of Disposition	/ Husbar		Place of Dispo	111		eet,		cimore 1	MD 2123 20c. Location		m. State
Baltimore,	permit. Pages Department of H important: If its any injury or of		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☒ Other (S	3 Removal from Sta	ite (cemetery, crei	matory or of	ther plac	1					
altin	permit. P Departme importan any injur;	i	21. Signature of Funecal Service			udon Par , Jr. a			s of Facilit	i⊼ unue T	1, 2004 al Home,	Baltır	rore Mar	yland
m	Depa impo any i		10.00			15	ories 01 Eas	t For	evens t Aven	runer we, E	al Home, <u>altimore</u>	Inc. MD 2123)	
E		9	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	sed the dear	th. Do not ent	ter the mode	e of dyin	g, such as	cardiac c	or respiratory ar	rrest,		Approximate Interval Between Onset and Death
760,	Physician /Medical Examiner /Medical Examiner / Physician and Physician and Physician and Physician are provided with the private of the physician are provided with the physician are provide	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Prue to (or c.	as a consec	quence of):	etino		٠,		mona	d bacte	cmia)	
.O. Box 68	death certific e attending pi d for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	n 2 ☐ Feta tat time of d	aldeath 3	□Ectopic pr						Pate of deliver	y Day Year
Δ.	The law requires that the site has been signed by the bage 2 should be detached.	by Pr	Part II. Other significant condition			-		_						cause of death?
Division of Vital Records,	w require been sig should b		History of VIII							e	1 🗆 🕆	Yes 2□No	3 🗍 Proba	bly 4 Onknown
Sec	The law rate has by page 2 st	Completed		rat plac							24a. Was autop		. Were autop prior to com death?	sy findings available pletion of cause of
alF		e Co	INJURY TCSP 25. Was case referred to medica	iral any fa	ulre	on chr	colc	van!			1 ☐ Yes	2 No		2□ No
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10	ding Phy h. After thi funeral o	n: T	27. Manner of Death 1 ☑Natural 5 ☐ Pendir	28a. Date of	-	28b. Time o		8c. Injun			28d. Describe I			
Sio	a ta :: e	Certification:	2 Accident investi	gation			М		Yes 2□		2011	0		
<u>S</u>	i or Attend after death i Director:	ertiff	4 Homicide determ	tined 286. Place of	Injury - At h , etc. (Speci	nome, farm, st ify)	reet, factory	r, office			28f. Location (S City or Tox		nber or Hurai	Houte Number,
_	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by ti	Medical Co		ng Physician: To the be Examiner: On the basi and manner	s of examina									
	within To the	Me	29b. Signature and title of certifie						e number	119		29d. Date sign		
)	Y		>K~Mon	rus (Kns	hna Medi	cal Res	MD	(+	hiz	111		jur	4 €,2	004
	10		30. Name and address of person Krishna Ma	who completed cause		m 23a) (Type	Print)	- 1,00	St	R	Ima	7 Mr		
	St	ate	31. Date filed (Month, Day, Year)		istrar's Sign		, , , ,	J11 L		124	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	- 110		
	Regist		1111 0 0 2004	Beneva	19	100	als	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Year **Physician** 2004 June 2, 10:05p M Muoi Sam /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Gaithersburg 15608 Bondy Lane 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Nov. 19, 1 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** 1 ☐ M 21 F 53 Ĩ/950 Vietnam 219-41-5226 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show d other than "naturel", or Items 23a or 28e-f shovevent, the Medical Examinar must be notified at MD 1 Tyyes 2 □ No Montgomery Darnestown Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 15608 Bondy Lane 20878 United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 Yes XXNo Specify: Specify: Asian þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home Dietary Aid 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked othwanty injury or other traumatic event ONCE. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Phan Duc Nghieu Quyen Sam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15608 Bondy Lane, Darnestown, MD Kit Chun Lee/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, MD 6/8/04 4 □ Donation 3 □ Other (Specify) Chesapeake Crematory 21. Signature of Funeral Service Licensee Simple Tribute Funeral and Cremation Center 1040 Rockville Pike Rockville, MD 20852 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Nasopharyngeal Cancer 4 years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and s the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 💢 No Certification: To this 28a. Date of Injury (Month, Day Year) Director: After the in by the funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours after To the Funeral Dire 29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

Baltimore, Maryland 21215-0036

Box 687685

o

Division of Vital Records, P.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph M. Haggerty

Eseph m. Hazzerty mi)

9707 Medical Center Drive, Rockville, MD

29d. Date signed (Month, Day, Year)

June 4, 2004

29c. License number

D32407

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

32. Registrar's Signature Joseph JUN 0 9 2004 P

				Please T					. Ensure A				
			For State Registrar		State of M	aryland /		artment of I	lealth and N Death	Mental Hy	/giene/ Reg. No.	2004	18197
F	Physici /Medio		Joseph	e (First, Middle, Last)	· • • • • • • • • • • • • • • • • • • •		dics			2. Date of De Month June	6, 20		3. Time of Death 11:50 P M
Fı	Examir uneral rector	ner		1 X	sing Home			4b. City, Town, of ToWSO		8. Date of Bi (Month, Da June 3	rth ay, Year)	Baltim 9. Birt P. Birt	
and	A ==		Usual Residence of 10a. State	Decedent 10b. County		10c. City, To	own or Lo	cation					10d. Inside City Limits
Maryl	e-f aho	tor	MD.	Baltimo	re		ındal						1 ☐ Yes 2 No
ith the	or 286	Director	10e. Street and Nur	mber				10f. Zip Code			10g. Citize	n of What Co	untry?
eath w	18 23a	erall	1713 Rita		12. Was Decedent	Francis II C	10.1	2122			USZ		
ING 21215-0036 be filed within 72 hours after death with the Maryland nat Hygiene.	d other than "natural", or Items 23a or 28e-f ahow event, Itia Medical Examinat must be notified at	by Funeral	11. Marital Status 1 ☐ Never Marri 3 🛣 Widowed	ed 2 Married	Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:		1	was Decedent of F f Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		. Race - Ame Black, White Decify: Wh	e, etc.
Maryland 21215-0036 d 2 should be filed within 72 hours af th and Mental Hygiene.	"natu	Completed	(Ѕрес	15. Decedent's Educify only highest grade	cation co <i>mpleted)</i>	10	6a. Deced	lent's Usual Occup	pation during most of work d)	ing	16b. Kind	of Business/	Industry
212 3 within giene.	r than	dwo	Elementary/Second 12 Years	ndary (0-12)	Coilege (1-4or 5	5+)		on Worke:	•		Unio	n Loca	1 16
nd be filed tal Hyg	d othe	Вес	17. Father's Name (18. Mother's Name		, Maiden Su		
laryland 2127 2 should be filed within and Mental Hygiene.	narke natic	٢	Joseph S	ladics ame/Relationship (Ty)	no Brintl		Ob. 14-00-	- 4-1	Elizabe				
and 2 si	L ==		Kathleen		daughter	- 1	713	g Address <i>(Street</i> Rita Road	and Number or Rundal	k, Md. 2	ө <i>г, City ar T</i> 1222	own, State, Z	ip Code)
Baltimore,	Importent: If item 2 any injury or other once.		20a. Method of Disp		emoval from State	20b. Place ceme	of Dispos etery, crem	sition (Name of natory or other place	ce)	Date	20c. Local	tion - City or	Town, State
Baltimor permit. Pages Department of	rtent: njury o			☐ Cremation 3 ☐ R 5 ☐ Other (Specify)		Belai			ard. June				
Balt permit. Departn	any ir		21. Signature of Full	neral/Service License		10000	7	Onnelly 110 Soll	Funeral He ers Point	ome Of	Dunda.	lk,P.A	21222
			23a. Part1. Enter the shock, or hear	ne disease of complint failure. List only on	cations that caused e cause on each lin	the death. In							Approximate Interval Between
	sician		Immediate Cause (disease or condition	Final	DEMENT1								Onset and Death
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the death certificate	ed by the attending pi detached for use as t	Physiclan/Medic	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal dea		Ectopic pregnancy Other (specify)	,		23d	. Date of deline Month	very Day Year
S 8	should be deta	by	Part II. Other signifi	icant conditions con	tributing to death bi	ut not resulting	g in the un	derlying cause giv	en in Part I.				the cause of death?
The law	ate has page 2	Completed		_						24a. Was autop perfor 1 \(\text{Yes} \)	rmed?	4b. Were aut prior to co death?	opsy findings available ompletion of cause of
	certificate irector, pag	o Be	25. Was case referr examiner?	Tu.	ospital:			Oth	26. Place of Death				
Jon OT Iding Phys	this rald	D: Lo	1 Yes 27. Manner of Death 1 Natural 2 Accident	NO	1 🗌 Inpatie 28a. Date of Injur (Month, Day		Outpatient Time of Injury	28c. Injun	4 A Nursing Hor	ne 5 🗌 Resid 28d. Describe h			fy)
To the Hospital or Attending within 24 hours after death.	al Director: ad in by the	Certificati	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injubulg	iry - At home, c. (Specify)	farm, stre	et, factory, office	:	28f. Location (S City or Tow	Street and No vn, State)	umber or Rur	al Route Number,
he Hospil in 24 hour	ro the Funeral Dir completely filled in	ledical	29a. Certifier (Check only one)	1X Certifying Phys 2 Medical Examin	ician: To the best of er: On the basis of and manner sta	examination a	ge, death and/or invi	occurred at the timestigation, in my of	ne, date and place, a pinion, death occurre	and due to the dead at the time, d	cause(s) and date and pla	d manner as s ce, and due t	stated. o the cause(s)
To t	com	Σ	29b. Signature and t	title of certifier				29c. License		- 1	29d. Date si	gned (Month,	Day, Year)
	0-		30 Name and addra	ess of person who cor	mpleted course of d	nath /Itam 00-	A) (Tues 5		3725		6	17/0	4
1	0			Q MAHMOOD	2300 DU				IMONIUM,	MD 2109	3		
Ř	Sta Registra		31. Date filed (Monti	h, Day, Year)		r's Signature	A A	F Son		2107			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 12:28 AM **Physician** fourth 2004 June Smith Mary Agnes /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) **Examiner** Union Memorial Hospital Baltimore 8. Date of Birth (Month, Dey, Year) Feb. 14,1933 Balto., Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 216 30 5818 71 Director Usual Residence of Decedent death with the Manyland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturel; or iteme 23a or 28a-f ehow empirity or other traumatic event, the Madical Examinational Le notified at once. 10a, State 1 ☐ Yes 2 ☐ No Completed by Funeral Director Maryland Baltimore Essex 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21221 **USA** 305 Margaret Avenue 12, Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Yes 2 □ No If Yes, Give X Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify. Specify: 3 ☐ Widowed 4 ☒ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restuarant Waitress 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) George Wells Scible Mary Josephine Karrigan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 305 Margaret Avenue Essex Maryland 21221 Ernest E. Brooks (informant) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【**Cremation 3 ☐ Removal from State ** 4 ☐ Dogation 5 ☐ Other (Specify) Bayview Crematory INC 6/5/04 Baltimore, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in reath) Pneumonia a weeks Physician /Medical Due to (or as a consequence of) Awk myocardial infarction **Examiner** 2 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical use as I IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 12 No 4☐Pregnant at time of death 5 Other (specify) signed by the aid be detached f P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 2 No 1 ☐ Yes 2 ☐ Mo 1 Yes spitel or Attending Physician: Thours after death.
Increase Director: After this certificate filled in by the funeral director, pt 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes _ 2 ☐ No 2 ER/Outpatient 3 DOA 2 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Van Nguyer, M.D. June fourth 2004

State Registrar

Van-Anh Thi Nguyen 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201 East University Parkway

AT2438946

Baltimore, MD 21218

			1 - For State Registrar	State of Marylan		artment o		and Mer	ntal Hygie	20	n la	18199
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ē,	other tr		John W. Swope, Jr 20a. Method of Disposition	20b. P	2006 lace of Dispo	Mars Ri sition (Name of natory or other)	un Road	ESSC Date	x, Mary	Land .		m. State
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Baltimore,	permit. Pages Department of Importent: If i any injury or one		21. Signature of Funeral Service Licens	- Lu	22 B1	ruzdzins	dress of Facility	eral H	iome PA		7,50	aryland
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	Physician /Medical Examiner		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	Stac	te D	emcr	rhig			11	nterval Between Onset and Death
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	(J		30. Name and address of person who co		23a) (Type, F	og R	201 17	a'l- a	1/2-	le n	130	11222
	Sta Registr	te ar	31. Date filed (Month, Day, Year, 2004	37 /F agistrar's Si nat		Spark	1/	(~ 47	1000			4

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Physician Month Dav Year 7, 2004 Frances Sears 4:50 am Lorraine June /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Baltimore
If Under 24 Hrs. Future Care Health - Homewood If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) **Funeral** Months Hours Min. Days 1 ☐ M 2 💢 F Yrs. Director <u> 229-16-1459</u> 81 12/03/1922 Virginia Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural; or items 23s or 28s-f show ury or other traumatic event, the Medical Examinar must be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Helmsman Court 21221 Α. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Race - American Indien Black, White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: þ Specify: 3 Noticed 4 Divorced White Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Long Lewis Della Mae Keyes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Department of Health Important: If Itam 27 William T. Sears (Son) 2 Helmsman Court Essex, Maryland 21221 20b. Plece of Disposition (Name of cemetery, cremetery or other plece)
Dulaney Valley Memorial
Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA nichael C 23a. Pert1. Enter the disease, or corpur cation of at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one charse on each line. 1407 Old Eastern Avenue Essex, Maryland 21221 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Atherostleratic Heart Examiner Due to (or es a consequence of): Examiner a actointed torce To the Hospital or Attending Physician: The law requiras that the death cartificate be associed within 24 hours after death.

To the Funerial Director: After this certificate has been signed by the attending physician and completaly filled in by the Indurated inector, page 2 should be deteched for use as the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 ☑ Unknown 1 Tyes 2 No 2 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? Discrete 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Medicai Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 Yes 2 No 3□ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Deeth 1 Neturel 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

| Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 617 104 D0051056 MD 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) MT Rayal Auc Balt MO レンバン 600 Dalscet Salvia MD 31. Dete filed (Month, 32. Registrer's Signature State Registrar

DHMH 16 Rev 6/95

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	Registr		JUN 0 9 2004	Grenery	~ B	10	ocky								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2004 **Physician** JUNE 3, 1:42 P M Shriner /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL CO ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1947 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Country)
Illinois 1 □ M 2X F 217-46-4536 **Director** Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. tnside City Limits 10a. State 10b. County r than "natural", or Items 23s or 28e-f show 1 Yes 2 No MD Anne Arundel Annapolis Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21401 1384 Sunwood Terrace USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: by 3 ☐ Widowed 4 🎖 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed withit Department of Health and Mental Hygiene. Important: if item 27 is marked other than any Injury or other traumatic access. College (1-4or 5+) Elementary/Secondary (0-12) Realtor Real Estate 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) Be Robert A. Larson Betty Monsen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ken Larson (Brother) 106 South Midfield Road, Linthicum, MD 21090 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 6/7/2004 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, MD 21. Signature of Funeral Septice Licensee 22. Name and Address of Facility
Hardesty Funeral Home, P.A. once Dalant unda 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** a OCCLUSIVE PULMONARY MROHOUEMBOUSH /Medical Due to (or as a consequence of): Examiner OF LEG DEEP VENDUS THROMBOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine signed by the attending physician and does detached for use as the burial-transit requires that the death certificate be executed LEG INJURY FOLLOWING that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records. 1 Yes 2 No 3 Probably 4 Munknown HYPERTENSION, DIABETES HORBIO OBESITY, peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an MELLITUS, ATRIAL FIBRILLATION autopsy performed 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 💢 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) XXYes 2 No this 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 28d. Describe how injury occurred funeral 27. Manner of Death 28b. Time of After Injury 1 Natural 5 Pending SUBTECT HAD 11:35 AM 613 104 after death. 1 Yes 2 10 investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1384 SUN WOOD TERRACE, ANNAPOUL RESIDENCE To the Hospitel within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier CCME JUNE 4, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , MD 111 Penn Street, Baltimore, Maryland 21201 ANA RUBIO

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JUN 0 9 2004

32. Registrar's Signature

			1 - For State Registrar	State of M	Maryland / Depa	artment of I		and Me		iene	2001	4 182	n:
			Decedent's Name (First, Middle,	Last)			-,	2	. Date of Death	1		3. Time of De	eath
	Physici /Medi		Kevin C1	lifford	Sirmons	s II			Month June	Day 3	2004	1715	М
ì	Examir		4a. Facility Name (If not institution, g		-	4b. City, Town, o	or Location o	of Death		4c. C	ounty of Deat	th	
			Anne Arundel Me			Annap				Ar	ne Aru		
	Funeral		_	.Sex 7.7 1 X M 2 ☐ F	Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours 2	Min.	Date of Birth (Month, Day,	Year)	Co	hplace (State or Fountry)	oreign
	Director		Unknown Usual Residence of Decedent		113.		Z	10 .	June 3,	200	14 Mar	yland	
	yland		10a. State 10b. County		10c. City, Town or Lo	cation						10d. Inside City I	Limits
	Mar B-f sh	to	MD Prince	Georges	Upper M	ar1boro						1 ☐ Yes 🔀	XN0
	th the	Director	10e. Street and Number			10f. Zip Code			10	g. Citize	on of What Co	ountry?	
	15 will	a	4405 Reverend I	avis Drive	е	2	0772			τ	ISA		
	72 hours after death with the Maryland natural', or tems 23a or 28a-1 show dicel Estatus termust by motified at	Funeral	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S. 13. \s?	Was Decedent of H	lispanic Orig	gin? (Specif	y Yes or No-	_	Race - Ame Black, White		
36	or ft	by Fu	XX Never Married 2 Married	If Yes, Give	No.	1 ☐ Yes 2 🛣 No		,	, 0.0.,	5			
Ö	hours turat'	d b	3 Widowed 4 Divorced	Year or Dates								Black	
15	d within 72 hours after spiene. In them "natural", or the medical Entire.	Completed	15. Decedent's (Specify only highest)	grade completed)	(Give	lent's Usual Occup kind of work done DO NOT use retire	during most	of working	,	6b. Kind	of Business/	Industry	
77	within iene.	шо	Elementary/Secondary (0-12)	College (1-4o	N/A		-,			N	/A		
Ö	ent,	BeC	17. Father's Name (First, Middle, La	st)	1 21/ 22		18. Mother	r's Name (F	First, Middle, M				
lan	2 should be and Mental Is marked c	G	Kevin Clifford	Sirmons			Ton-	ja Mos	selev				
Maryland 21215-0036	should and Men s marke umatic		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	g Address (Street				City or T	own, State, Z	Zip Code)	
	5 4 7 E		Kevin Clifford	Sirmons (Father) 440	5 Revere	nd Day	vid Dr	., Upp	er M	arlbor	o, MD 20	772
ore	es 1 a of Hea of Itam r othe		20a. Method of Disposition 1 □ Burial 2 X Cremation 3	□ Bomoval from Star	20b. Place of Dispo cemetery, cren	sition (Name of natory or other plan	ce)	Date	2	Oc. Loca	tion - City or	Town, State	
Ĕ	Pages ment of ant: if its ury or o		'4 □Donation 5 □Other (Spec		Metro Cre	matory	6	5/9/20	004 Ва	alti	more,	MD	
Baltimore,	permit. Pages Department of H Important: if Its any injury or of		21. Signature of Foneral Service Lic	ensee de Al	1 22	Name and Addre Hardesty 12 Ridge					MD 21	401	
	9.		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caus	ed the death. Do not ent						MU 21	Approximate	
1	Physician		Immediate Cause (Final disease or condition	y one cause on each	Extrem	o Pri	emal	ton	Ly		(9)	Interval Betwee	
	/Medical		resulting in death)	a. Due to (or a	as a consequence of):				1			2 h/3.10	de
	Examiner		Sequentially list conditions,	b							le	J-1113.10	
	D ==	Iner	if any, leading to immediate cause. Enter Underlying	Due to (or a	as a consequence of):								
	and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	C									
8760,	ate be executed physician and the burial-transit			Due to (or a	as a consequence of):								
387	physis the	dical		d									
9 x	death certificate be executed e attending physician and od for use as the burial-transit	by Physician/Me	IF FEMALE:	23c. If yes, outcom	ne of pregnancy								
Вох	atter after 1 for L	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth	2 Fetal death 3	Ectopic pregnancy Other (specify)	/			230	 Date of delification Month 	very Day Year	r
0	the c y the achec	lys	9 Unknown	9□ Unknown									
s, D	The law requires that the de ite has been signed by the a page 2 should be detached f	y P	Part II. Other significant conditions	contributing to death	but not resulting in the un	derlying cause giv	en in Part I.		23e. Did toba	icco use	contribute to	the cause of deat	h?
rd	w require been sig should b								1 🗌 Yes	2	3 □ Pro	bably 4 Unkr	nown
Record	aw requise been 2 shouk	Completed							24a. Was an	:	24b. Were aut	topsy findings avai	ilable
m m	The lav	E							autopsy performe	ed? ⊋≥No	death?	ompletion of cause 2 No	9 01
Vital	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?				26. Place	of Death (C	heck only one	-		20110	
× ×	Q S	2	1 ☐ Yes 2 😭 🕉 🕽 o		tient 2 ER/Outpatien	: 3□ DOA Oth	er: 4 🗆 Nur:	sing Home	5 Residen	ce 6[Other (Spec	ity)	
ב	ing P	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of In (Month, D	jury 28b. Time of Injury	28c. Injur Wor	y at k?	28d	. Describe how	injury o	ccurred		
<u>sio</u>	Attanding ir death. ector: After by the fune	catl	2 Accident investigate 3 Suicide 6 Could not	be			Yes 2 □ N						
Division of	f or Attanding after death. Director: After I in by the funer	Certification:	4 Homicide determine	289. Place of II	njury - At home, farm, stre etc. <i>(Specify)</i>	et, factory, office		28f.	Location (Stre City or Town,		lumber or Rui	ral Route Number,	
_	ospitat hours a uneral I ly filled		29a. Certifier	Physician Tarks have	A of our lower do do do do do			_ /					
	Hospital 24 hours Funeral stely filled	edical	(Check only 2 Medical Expone)	rnysician: 10 the bes aminer: On the basis and manner s	st of my knowledge, death of examination and/or investated.	occurred at the tin estigation, in my o	ne, date and pinion, death	l place, and h occurred a	due to the cau at the time, date	se(s) an e and pl	d manner as : ace, and due :	stated. to the cause(s)	
	To the Mospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and title of certifier	//	. 1	29c. Licens	e number		290	i. Date s	igned (Month,	Day, Year)	
)	->-0		Malon d.	last	. 1/t.m) Dim	3549	6			_	2004	
			30. Name and address of person who	o completed cause of	death (Item 23a) (Type. I		J.J. []	*					
			2001 Medical f	tay to	100 B. MJ	Ac Del	og H	-4-	Carto	Pro	nt		
E	Sta	-	31. Date filed (Month, Day, Year)	All	trar's Signature								
	Registr	ar	JUN 0 9 200	- Course	IF DOBAL	0							

			1- For Amend Item !	per FH,G	532,06/16/	ertificate of L	eaith and ivi D <i>eath</i>	ental Hyglei	/ 1 1 1 1 1 1
I	Physici		Decedent's Name (First, Middle, La JUL I		В.	SCHERR		2. Date of Death	Day 6, 2004 8:02 A M
	/Medic Examir		4a. Fecility Name (If not institution, give			1	Location of Death		4c. County of Death
			6501 SANZO ROAD	#B			BALTIMOR	E	BALTIMORE
	Funeral Director		5. Social Security Number 6. 5 215-10-7449	Gex 7. Ag 1 ☑ M 2 ☐ F	e (In yrs. last birthda 89 Yrs.	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye DEC. 17, 19	9. Birthplace (State or Foreign Country) MD
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	_ocation			10d. Inside City Limits
	Many -1 sho	tor	MD BALT	IMORE	RAI -	ΓIMORE			1 ☐ Yes 2 ☑ No
	or 28a	rec	10e. Street and Number		DATE	10f. Zip Code		10g.	Citizen of What Country?
	23a c	alD	6501 SANZO ROAD	#B			21209		U.S.A.
36	hours after death with the Maryland lurel', or items 23a or 28a-1 show at Evar: a wr must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 1 1 Yes, Give Year or Dates:		. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (Spe n, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
21215-0036	n 72 hours "naturel",	ted I	15. Decedent's E	ducation	16a. Dec	edent's Usual Occupa	ition	16b	. Kind of Business/Industry
215	d within 72 ho piene. r then "natur the Medical	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5)+)	e kind of work done d DO NOT use retired)		ng	,
21			12		OWN	R/DISTRIB			EWSPAPER
Maryland	be od o	Ве	17. Father's Name (First, Middle, Last, BERYL)	SCH		18. Mother's Name	(First, Middle, Maid	
Z	shoutd ind Men inarke imarke	T _o	19a. Informant's Name/Relationship (Type, Print)			HELEN	Route Number Cit	ASHMAN y or Town, State, Zip Code)
	s 1 and 2 should f Health and Mer item 27 Is marke other treumatic		JOSEPHINE SCHERR	*		SANZO RO			
ore,	ges 1 a t of Hea If item or othe		20a. Method of Disposition	20	20b. Place of Disc		Da		Location - City or Town, State
ij	Pages ment of ent: If it ury or o		1		I .	I CEMETER	· I	004 0	WINGS MILLS, MD
Baltimore,	permit. Pag Department Importent: I eny injury o once.		21. Signature of Funeral Service Licer	Town T		22. Name and Address	JUL	LEVINSON	& BROS., INC. ESVILLE, MD 21208
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not en	nter the mode of dying	, such as cardiac or	respiratory arrest,	Approximate Interval Between
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Congle	a consequence of):	nd FAILVA	•		Onset and Death
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	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		a consequence of):				
	ecute and I-trans	Examiner	that initiated events resulting in death) Last	C. Due to (or se	a consequence of):				
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687	ificate g phys	edlcal		. d					
.O. Box	The law requires that the death cert lie has been signed by the attendin, bage 2 should be detached for use a	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome of the control	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delivery Month Day Year
4	res that signed b	by Pr	Part II. Other significant conditions of	ontributing to death bu	at not resulting in the	underlying cause giver	n in Part I.	23e. Did tobacco	o use contribute to the cause of death?
ords	w require been sig should b	ted b	porcy to pema					1 🗆 Yes	2 No 3 Probably 4 Unknown
Records,	The law rete has be sage 2 sho	Completed						24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital	ysicien: The is certificate hadirector, page	Bec	25. Was case referred to medical examiner?				26. Place of Death (lo 1 □ Yes 2 □ No
of <	Physicien: r this certificanal director,	2	1 ☐ Yes 2 💢 No	Hospital: 1 ☐ Inpatier		nt 3 DOA Other	4 Nursing Home	e 5 🛣 Residence	6 □Other (Specify)
on c	ling Phys After this funeral di	lon:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time of Injury	Work?		3d. Describe how inj	ury occurred
Division	Attending or death. sctor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be		ry - At home, farm, si		es 2 No	of Location (Street	and Alumbar as Court Court November
<u>≤</u> .	al or A after Direct	Certification:	4 Homicide determined	building, etc	. (Specify)	reet, ractory, office	20	City or Town, Sta	and Number or Rural Route Number, te)
	Hospi 24 hou Funer stely fill	edical (29a. Certifier 1 X Certifying Ph (Check only one)	ysician: To the best on niner: On the basis of and manner stat	examination and/or in	th occurred at the time evestigation, in my opin	a, date and place, an nion, death occurred	nd due to the cause(d at the time, date as	s) and manner as stated. nd place, and due to the cause(s)
	To the within To the comple	M	29b. Signature and title of certifier			29c. License	number	29d. D	ate signed (Month, Day, Year)
)	<u></u>		·	1	-2-12-12-12-12-12-12-12-12-12-12-12-12-1	03	77 77	6	1/1/04
	10		30. Name and address of person who	completed cause of de	path (Item 23a) (Type	Print)	1209	,	
	Stat Registra		31. Date filed (Month, Day, Year) JUN 0 9 2004		r's Signature	Marke			

Physician

f show

Hygiene.

permit. Pages 1 and 2 should be I Department of Health and Mental I Importent: If item 27 ts marked o

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

Year

2. Date of Death

Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** June 3:00 A Donna Marie Teal 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Franklin Square Hospital Center Rosedale Baltimore 8. Date of Birth (Month, Day, Year)

July 23, 1959 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗓 F Hours 216-56-8719 44 Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show 1 ☐ Yes 2 X No Director Maryland Baltimore White Marsh 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23e or 5834 Loreley Beach Road 21162 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. hours after I ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 2 1 ☐ Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Homemaker Own Home and Mental Hygier I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pilone. Raumond Gudenius Nancu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Itam 27 la
any njury or other trau 5834 Loreley Beach Road, White Marsh, MD 21162 Mr. David M. Teal (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory 6/10/2004 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licenses 9705 Belair Rd., Baltimore, MD 21236 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiogenic Shock Right sided heart Failure **Physician** month /Medical Due to (or 15 a consequence of): **Examiner** irrhosis 415 Sequentially lifet our different any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed Alcoholism 20 YRS physician and s the burial-trans Due to (or as a consequence of): Box 68760, by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown ۾ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed 2 No of Vital or Attending Physician: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ours after death.
nerel Director: After the filled in by the funeral 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Division 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funerei Completely filled it 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Sidhaye 20060186 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Prive, Baltimore, MB.21237 Dr. Venkatataman Sidhaye

Registrar DHMH 17 Rev 1/2001

State

eal Donna OV

32. Registrar's Signature

		A	State of Maryland / Dep MEND ITEM #1 PER PHY G832 6/09/04 J&			giene Reg. No. 200 i	· 18207
			1. Decedent's Name (First, Middle, Last)		2. Date of De		3. Time of Death
	Physic		Taylor, Millie M. MILLIE M. TA	YLOR	Month O5	Day Year	
}	/Medi Examir		4a. Facility Name (If not institution, give street and number)		City, Town, or Locetion of Deat	01000	
	= 701171		Crumland Farms Health Center	F	rederick	Frede	rick
	Funera!		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		Under 24 Hrs. 8. Date of Bi	rth 9. B	rthplace (State or Foreign
	Director		296-03-1624 1□M 2₽F 92 Yrs.	Months Days H	Iours Min. Dec. I	, 1911 M	ichigan
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or I				
	eryla shov	_	100 019,7 0111 01 2				10d. Inside City Limits
	Pe M	Director		erick			1 ☐ Yes 2 ☐ No
	72 hours efter death with the Meryland netural', or itema 23a or 28a-f show dical Examine must be notified at	늅	10e. Street and Number	10f. Zip Code 21701		10g. Citizen of What C	country?
	eath mark	Funerai	2490 Five Shillings Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.				
_	ter d	Ş	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	If Yes, specify Cuban, M	nic Origin? (Specify Yes or No lexican, Puerto Ricen, etc.)	o- 14. Race - Am Black, Wh	
20	irs ef	-	3 ₩ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 🕅 No Sp	pecify:	Specify:	White
9	n 72 hours eft "netural", or l edical Exami	Completed by	15. Decedent's Education 16a. Dece	edent's Usual Occupation	1	16b. Kind of Business	s/Industry
218	Med 7	Die	(Specify only highest grade completed) (Give life.	e kind of work done durin DO NOT use retired)	g most of working		,
21	d wit	ĕ	2	Nurse		Health C	are
멀	office office Vent	Be	17. Father's Name (First, Middle, Last)	18.	Mother's Name (First, Middle	,	
Va	Menta Menta Menta Mice	2	Karl H. Newton		Nellie B. Mi	ller_	
Maryland 21215-0020	2 sho end l is me		19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ing Address (Street and I	Number or Rural Route Numb	er, City or Town, State,	Zip Code)
~	end ealth n 27 ner tr		Mrs. Diane Cleveland (Daughter) 8220		Ct., Frederick	t, MD 21701	
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours Department of Health end Mental Hygiene. Important: If item 27 is marked other then "netural! any Injury or other traumatic event, the Medical Exponse.	12	20a. Method of Disposition 20b. Place of Disposers 20c. Place of Dis	osition (Name of ematory or other place) n Mem. Garde	Date C / O / O /	20c. Location - City or	
Ë	men tant: jury		4 Donation 5 Done (Specify)			Marriottsv	
Ba	Depar mpor mpor my In		21. Signature of Funeral Service Licensee	2. Name and Address of HAIGHT FUNE	Facility RAL HOME & CHA	APEL. PA (B	ox 195)
	40140		Duan a, svanza	Sykesville,	MD 21784 (410	0)-795-1400	1.07
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, su	uch as cardiac or respiratory a	rrest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final	7 //	1		Onset and Death
	Examiner		disease or condition resulting in death)	of Mela	noma		
	\Box	ē	Due to for as a conse	quence of):			
	d d ensit	edicai Examiner	Sequentially list conditions.				
oʻ	icete be executed physiclan and s the buriel-trensit	EXS	sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	querice or).			
68760,	te be ysick ne bu	cai	that initiated events	quence of):	<u>-</u>		
			resulting in dealify Last	,			
Вох	The law requires that the death certif ete has been signed by the attending page 2 should be deteched for use e	Physician/M	d		Tig.		
<u>.</u>	e dea the at	Sici	Part II. Other significant conditions contributing to death but not resulting in the u	ınderlying cause given in	Part I. 23b. Did	lobacco use contribute	to the cause of death?
о. О	d by letech	£	Demontes He Deat	Danie.	10	Yee 2. No 3□P	robably 4 Unknown
ည်	ires ti signe	<u>\$</u>	Samuel Jugger	erusur 1	/		
Records,	neen Seen Shouli	Completed	alpucanca			rmed?	Were autopsy findings available prior to completion of cause
န္တ	2 55 8	킅	Jacob 12				of death?
a	cete				101	res 2 No	1 ☐ Yes 2 ☐ No
Vital	icien: Th	Be	25. Was case referred to medical examiner? Hospital:	26.	Place of Death (Check only of	ne)	
ō	Tal di	2	1 Inpetient 2 ER/Outpatier	nt 3LI DOA 4	Nursing Home 5 Resid		city)
5	After fune	뎚	1 Natural 5 Pending (Month, Day Year) Injury	of 28c. Injury at Work? M 1 □ Yes		now injury occurred	
Division of	Attending Physicien: or death. ector: After this certifice by the funeral director.	fica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home farm str			Street and Number or Ru	iral Route Number
Š	if or / effer Dire	Certification:	4 ☐ Homicide Getermined building, etc. (Specify)	001, 1201019, 011100	City or Tou	m, State)	and ricule realition,
	To the Hospital or Attending Physicien: The li within 24 hours efter death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier Check only Ch	n occurred at the time, da	ate and place, and due to the	cause(s) and manner as	stated.
	in 24 he Fu pletel	edical	one) 2 Medical Examiner: On the basis of examination and/or in	vestigation, in my opinion	n, death occurred at the time,	date and place, and due	to the cause(s)
	With Tot	Σ	29b. Signature and title of certifier	29c. License num	nber	29d. Date signed (Mont	h, Day, Year)
	15		Me Hegensett M	0 035	183	Man	29,200cm
	10		30. Name and address of person who admitted cause of death (Item 23a) (Type,	Print)	3460+0	1	1000
			31. Date filed (Month, Day, Year) 32. Registrar's Signature	xo or	11.20 16	AELICK	1000
	Stat Registra		JUN 0 9 2004	sparked			

1			1 - For State Registrar		Maryland / Depa	artmen rtificate			and M	R	eg. No. 2	004	18208
1	Physici	an	1. Decedent's Name (First, Middle Willis	e, Last) E •		Tucke:	r			2. Date of Dea Month	Day	Year	3. Time of Death
1	/Medio		4a. Facility Name (If not institution					Location o	f Death	June	T	004 ty of Death	0333
	LAGIIII		Anne Arundel	Medical Ce	nter	Ann	apo1	is					
	Funeral Director		5. Social Security Number 212-34-7679 Usual Residence of Decedent	6. Sex 7 1 XM 2 ☐ F	'. Age (In yrs. last birthday) 66 Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Birth (Month, Day) Feb. 17	,1938	9. Birth Cou Mar	pplace (State or Foreign intry) y Land
	e Maryland Sa-f ahow	ctor	10a. State 10b. County	Arundel	10c. City, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2√ No
	with the	Dire	10e. Street and Number 407 Beach Dri	W0		10f. Zip	Code 214	0.3		1	_	f What Cou SA	intry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-1 ahow any injury or other traumatic event, it a Medical Exact and item to after a notice.	by Funeral Director	11. Marital Status 1 Never Married 2 Marr XXWidowed 4 Divorced	12. Was Deced	XNo	Was Deced If Yes, spec	lent of Hi		gin? (Spi , Puerto	ecify Yes or No- Rican, etc.)	14. Ra	ace - Ameri ack, White	, etc.
21215-0036	d within 72 ho piene. r than "natur tha Medical	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)		(Give life.	dent's Usua kind of wor DO NOT us nter	k done o	lurina most	of work	ing			3. Time of Death 24 0555 M O555 M OF Death Arundel 9. Birthplace (State or Foreign Maryland 10d. Inside City Limits 1 Yes X No That Country? A American Indian, White siness/Industry Iction 2) State, Zip Code) 21666 City or Town, State Ls, MD 0 21401 Approximate Interval Between Onset and Death 3 DAT Oute to the cause of death? Birthobably 4 Dunknown of delivery th Day Year Oute to the cause of death? City or Town, State City or Town, S
Maryland	ould be filed 3 Mental Hyg narked othe natic event,	To Be C	17. Father's Name (First, Middle, William E. Tu	cker				S	ara	E. Hard	esty		
Mar	id 2 sh Ith and 27 Is m traum		19a. Informant's Name/Relations James Asquith							al Route Number :evensvi			
Baltimore,	Pages 1 and 2 ent of Health a nt: If item 27 is y or other trau		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	3 □Removal from S	20b. Place of Dispo	sition (Nam natory or of	ne of ther place	9)		Date	20c. Location	- City or T	own, State
Balti	permit. Departm Importar any inju		21. Signature of Sundraf Service		11	Name and	d Addres	s of Facility Fune	ral	Home, P	.A.		
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Due to (o	used the death. Do not ent chiline. CACACA r as a consequence of):								Approximate Interval Between
. 68760,	rtificate be executed ng physician and as the burial-transit	Medicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (o	r as a consequence of):								
.O. Box	Attanding Physician: The law requires that the death certific ir death. actor: Atter this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as it.	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live bir	nt at time of death 5	Ectopic pre Other (spe						ate of deliv	,
Records, P	w requires that the de been signed by the a should be detached f	ρχ	Part II. Other significant condition	ons contributing to dea	th but not resulting in the u	nderlying ca	iuse give	n in Part I.			acco use con s 2 □ No	10	
	ifcian: The law r certificate has be rector, page 2 sh	Completed								24a. Was ar autops perform 1 Yes 2	y	prior to co death?	impletion of cause of
Vital	ysicial s certif	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{The} \)	Hospital:	atient 2 ER/Outpatien	t 3 DO	Othe			ne 5 ☐ Reside	0.00	hor (Engain	4.1
Division of	ittanding Phy death. ctor: After thi y the funeral o		27. Manner of Death 1 Hatural 5 Pendin 2 Accident Investig	28a. Date of (Month,			Bc. Injury Work		1	28d. Describe ho			y)
Divis	i gite o	Certification;	3 Suicide 6 Could r 4 Homicide determ	ined 286. Place of building	f Injury - At home, farm, str g, etc. (Specify)					City or Town	, State)		
	To the Hospitel or within 24 hours after To the Funeral Difficant completely filled in	Medical	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physicien: To the b Examiner: On the bas and manne	est of my knowledge, death its of examination and/or inverstated.	occurred a restigation,	it the time in my op	e, date and inion, death	place, a	and due to the ca ed at the time, da	use(s) and m ite and place,	anner as s	tated. o the cause(s)
•	To the within To the Comp	ž	29b. Signature and title of certifier	1 mp		C	License	number	49	74	6/8	A O	Oay, Year)
	1,		30. Name and address of person	who completed cause	of death (ftem 23a) (Type.	Print)	Anc	nde	1	Medic	er (eut	er
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 9 200	32. Reg	gistrar's Signature	1 000 W.	,						

Wzgare, Purushottam. 8760, Baltimore, Maryland 21215-0036

			1 - For State Registrar		d / Department of Healt Certificate of Dea	th and Mental Hy	ygiene	18200
	Physic /Medi		1. Decedent's Name (First, Middle,	P. Uzgare		Month	eath Day Year	3. Time of Death
7	Exami		4a. Facility Name (If not institution, Franklin Squa	re Hospital Cer	4b. City, Town, or Locat The Rosedale	tion of Death	4c. County of Death	ore.
	Funeral Director		5. Social Security Number N/A Usual Residence of Decedent	7. Age (In yrs.)	Yrs. If Under 1 Year If Ur Months Days Hou	nder 24 Hrs. B. Date of B. (Month, D. Sept.	irth (ear) 932 9. Birth	nplace (State or Foreign uptry) and
	ath with the Marylan s 23a or 28a-f show asst be rediffed at	ector	10a. State Maharashtra Country - India	N/A	, Town or Location Mumbai (Bomba	y)		10d. Inside City Limits 1 Yes 2 □ No
	ath with I	Funeral Director	10e. Street and Number 6/109 Chaitan	yanagar, Santa (-055	India	untry?
980	72 hours after death with the Maryland natural', or Items 23a or 28a-f show alsoal Exartinet and Leurstiffed at	b	11. Marital Status 1 ☐ Never Married 2 🕱 Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:	S. 13. Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 ☐ Yes 2 💢 No Specific Cuban, Mex			e, etc.
Maryland 21215-0036	e * 39	Be Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) Accountant	most of working	Mental Hygiene Reg. No. 2004 S 2009 2. Date of Death Month Day Year 5: 41 p M 4c. County of Death Building (State or Foreign Toughty) 8. Date of Birth Country? Sept. 11, 932 9. Birthpace (State or Foreign Toughty) 10g. Citizen of What Country? India 10d. Inside City Limits 12 Yes 2 no 10g. Citizen of What Country? India 16b. Kind of Business/Industry Wilson College me (First, Middle, Maiden Sumame) Wal P. Uzgare Wal Route Number, City or Town, State, Zip Code) d., Perry Hall, MD 21128 Date 20c. Location · City or Town, State 8, 2004 Baltimore, Maryland himunek Funeral Homes Bultimore, MD 21236 cor respiratory arrest, 23d. Date of delivery Month Day Year 23d. Date of delivery Month Day Year 23d. Date of delivery Month Day Year 23d. Date of delivery Month Day Year 23d. Date of delivery Month Day Year 24d. Was an autopsy findings available given on the course of death? 1 yes 2 No 3 probably 4 unknown 24a. Was an autopsy findings available given on the course of death? 1 yes 2 No 1 ye	
and 2		Be Co	17. Father's Name (First, Middle, La Premchandra K.		18. M		e, Maiden Sumame)	rege
Mary	# 12 B	1	19a. Informant's Name/Relationshi Rajneesh P. Uzg	o (Type, Print)	19b. Mailing Address (Street and Nu	imber or Rural Route Numb	ber, City or Town, State, Z	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 4 □ Donation 5 □ Other (Spe	20b. Pl	ace of Disposition (Name of emetery, crematory or other place) Wiew Crematory	Date	20c. Location - City or 1	Town, State
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service Li		22. Name and Address of Fa	acility Schimunek	Funeral Hom	ies
	Physician /Medical Examiner		23a. Part1. Enter the disease, or conshock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequ			arrest,	Approximate Interval Between Onset and Death
8760,	be executed ician and burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence)	ence of):	on		
.O. Box 6	death certiti e attending p id tor use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3 Ectopic pregnancy		1	,
rds, P	w requires that the been signed by th should be detache	by	Part II. Other significant condition	s contributing to death but not resu	lting in the underlying cause given in Pa		12	
Il Records,	The law rate has be page 2 sh	Completed				auto perfo	psy prior to co ormed? death?	ompletion of cause of
Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	Other	lace of Death (Check only		
of		⊢ ∤	1 ☐ Yes 2 No 27. Manner of Death	1 Ainpatient 2 Lie	28b. Time of 28c. Injury at			fy)
ion	Attanding F r death. sctor: After by the funer	atloi	1 Natural 5 ☐ Pending 2 ☐ Accident investigat		Injury Work? M 1 ☐ Yes 2	? □No	,	
Division	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely tilled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		ne, farm, street, factory, office	28f. Location (City or To	Street and Number or Run wn, State)	al Route Number,
	the Hospi in 24 hou the Funer pletely till	edical	one) 2 medical Ex	Physician: To the best of my know aminer: On the basis of examinati and manner stated.	rledge, death occurred at the time, date on and/or investigation, in my opinion, o	and place, and due to the death occurred at the time,	cause(s) and manner as s date and place, and due t	stated. to the cause(s)
	1/	×	1.1	ILALL MO	29c. License numb			* * * * * * * * * * * * * * * * * * * *
	9		30. Name and ddress of person who	o completed cause of death (Item	23a) (Type, Print)	Davis P. 12'		01227
	Sta	te	31. Date-filed (Month, Pay Year)	A Registrar's Signatu	South	erive Dauti	more, ind	10014

			1- For State Registramend Ite	State of M em#29d, per D	laryland/Depa R, G832,66	artment of H HifteleCof I	lealth and M Death		giene Reg. No.201	04 18210
	Physici	an	1. Decedent's Name (First, Mic		1			2. Date of De	ath	3. Time of Death
	/Medi		Roscoe			Willia		June		25, 10 M
1	Examir	er	4a. Facility Name (If not institut		0 1	0 1 -	Location of Death	C.Z.	4c. County	of Death
	Funeral		Sinai H		Baltimore ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th	9. Birthplace (State or Foreign
	Director		237-20-9164	7 € M 2□F	85 Yrs.	Months Days	Hours Min.	(Month, Da	y, Year)	Birthplace (State or Foreign Country) NC
	pu k		Usual Residence of Decedent 10a. State 10b. Coun	ntv	10c. City, Town or Lo	nation				
	daryla f sho	ō			Baltim					10d. Inside City Limits 1 X Yes 2 □ No
	ith the Marylan or 28e-f show s notified at	Director	10e. Street and Number	NA	Daiti	10f. Zip Code			10g. Citizen of W	/hat Country?
	th with 23a o	<u>a</u>	3010 Virgin	oia Arro		21	215			3.A.
	eme	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S. 13.1		ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race	- American Indian, c, White, etc.
36	ours after death with the Maryla ai' or iteme 23a or 28e-f shov Examinar must be notified at	by Fu	1 ☐ Never Married 2☐M 3 ☐ Widowed 4 ☐ Divorc	If Yes Give	No	1 □ Yes 2 X 1Xio	Specify:		Specify:	
Maryland 21215-0036		ted t	15. Deced	ent's Education		dent's Usual Occupa	ation		16b. Kind of Bus	
218	thin 7 e	Completed	(Specify only high Elementary/Secondary (0-12	hest grade completed) College (1-4or	(Give life.	kind of work done of DO NOT use retired	ation during most of worki ()	ing		
21	filed wi Hygien other th	S	7th grade	na	Ma	intenan				ent Complex
and	s be fill ntal H ed otl	Be	17. Father's Name (First, Middle				18. Mother's Name	,		9)
Ž	2 should be filed within and Mental Hygiene. le marked other than eumatic event, than we	ဥ	James Willia 19a. Informant's Name/Relatio		19b. Mailir		Isabella and Number or Rura			State Zin Code)
	s 1 and 2 should be filed within 72 hr I Health and Mental Hygiene. Item 27 ie marked other than "natu other treumatic event, Ita Medical		Christine E.							
ore,	es 1 a of Hea fitem rothe		20a. Method of Disposition		20b. Place of Dispo	sition (Name of natory or other place		Date		City or Town, State
Ĕ	Page ment ent: If ury o		`4 □ Conation 5 □ Other	n 3 □Removal from State (Specify)	Woodlawn		1	/04	Baltimo	ore Co, Md
Baltimore,	permit. Pages 1 and Department of Health Importent: If Item 27 any njury or other tronce.		21. Schalling of Funeral Service	ce Licensee	L. M	arch F	H West			
100	703 £ 0		23a. Part1. Enter the disease,	or complications that cause						1d 21215 Approximate
	DI VIV		shock, or heart failure. Li Immediate Cause (Final	ist only one cause on each	line.	er trie mode or dynn	g, such as cardiac c	л төзрлатогу ат	1651,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Hear	s a consequence of):					lyear
-1	Examiner			seven		2 84e1	nosis			lvear
	р # <u></u>	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for a	s a consequence of		141			-
	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Athe	ro Scle ro 1	tic ve	art d	iseas	se	> years
68760,	sician buria									/
89	tificate I g physi as the b	ledical		d				-	-	
Вох	eath certifi attending for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 □ Live birth	e of pregnancy 2 Fetal death 3	Ectopic pregnancy	4			of delivery
	it the dea by the at tached fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			Other (specify)			Mont	th Day Year
P.0	that the od by detac	Ph)	Part II. Other significant condi	itions contributing to death	but not resulting in the u	nderivina cause give	en in Part I.	23e. Did to	bacco use contril	bute to the cause of death?
ds,	luires tha n signed ild be de					, ,		1 🗀 Y	′es 2□No 3	3 Probably 4 Unknown
~ <u>0</u>	aw require s been si 2 should b	Completed						24a. Was		ere autopsy findings available
Re	The tav	,om						autop perfor	meda de	ior to completion of cause of eath? □ Yes 2 No
/ita	ysicien: Th is certificate director, pag	Be	25. Was case referred to media examiner?				26. Place of Death			
of	Physi this c	. To	1 Yes 2 No	Hospital: Inpat			4 Nursing Hor		lence 6 Other	1 1 //
on	ding F h. After funer	tlon	1 Natural 5 Pend	28a. Date of Inj ding stigation	ay Year) 28b. Time of Injury	28c. Injury Work	yat ⟨? Yes 2 No	zad. Describe n	ow injury occurre	α
Division of Vital Records,	Attending Physicien: ir death. ector: After this certifics by the funeral director, p	Certification:	3 Suicide 6 Coul	ld not be 28e. Place of Ir	jury - At home, farm, str			28f. Location (S	Street and Number	r or Rural Route Number,
Ö	tel or s afte el Dir	Cert	4 Nomicide	building, e	tc. (Specify)		1	City or Tow	n, State)	
	Hospi 4 hour Funer ely fill		(Check only	ying Physician: To the best al Examiner: On the basis	t of my knowledge, death	occurred at the time	ne, date and place, a	and due to the o	cause(s) and man	ner as stated.
	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	Medical	one) 29b. Signature and title of certifications	and manner s	tated.	29c. License				(Month, Day, Year)
	£ 3 £ 8) in	uD					-	
	1/	7	30. Name and address of person	on who completed cause of	death_(Item 23a) (Type,	Print)	S-OCC Hospita		6/5/04	
	A.		30. Name and address of person			Sinai	Hospita	el at	Balti	ner
	Sta Registr		31. Date filed (Month, Day, Yea JUN 0 8 20		rar's Signature		•			
				- 1	N	20ckal				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month **Physician** ose 2:30 PM une /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Bon Secours Hospital If Under 1 Year | If Under 24 Hrs. **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2 🔀 F Yrs. Director 93 215-22-1112 Usual Residence of Decedent 04 MD 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits r Itams 23e or 28e-f show in ar must be notified at Director MYes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2328 West Mosher Street 21216 U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ant: If itam 27 Is marked other than "netural", or Ital 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo other traumatic avant, the Madigal Evan 3√Widowed 4 □Divorced Specify Black Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Fitter Glenn Martin Corp. na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis Jordan Rose Forbes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8609 Rockcress Ct. Columbia, Md 21045 Rose Waters-Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Maurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ŏ permit. Page Department of Important: If any injury or once. New Cathedral 6/12/04 Baltimore Md. of Juneral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Carcinoma Immediate Cause (Final Priysician of unknown Primary disease or condition resulting in death) /Medical Due to (or as a consequent Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) the for use as IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) of Vital Records, P.O. detached 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pertusion 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Ves 2 **X** No 1 Yes or Attanding Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled To the Hospital within 24 hours a To tha Funaral C Scentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of the basis of the analysis of the basis of the place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check on one) and manner stated. 29b. Signature and title of certifier 29c. License number House Officer

DHMH 17 Rev 1/2001

D

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 9 2004

2000 Weststreet,

Dal times P

SS of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

	Ti.	1 - For Amend & Un State Registrar 1. Decedent's Name (First, Middle		71,256,	Cei	tificate of	Death	2. Date of D		704	3. Time of Death
Physic /Medi		Michele J. Warge	Michelle	e Wargo				June	01,	2004	06:30 A ^N
Exami		4a. Facility Name (If not institution,		•		4b. City, Town, o		ath		ty of Death	
Funeral		Upper Chesapeal 5. Social Security Number		Age (In yrs. la:		Bel A	If Under 24 H			rford 9. Births	lace (State or Foreig
Director		142-64-2669	1□M 2 X F	29	Yrs.	Months Days	Hours Mi		Day, Year) 3. 197 5	Cour	ntry) NT
D		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				1	Od. Inside City Limits
Mary a-fsh	tor	NJ Mc	rris			Netcang					1 XYes 2 ☐ No
death with the Maryland ms 23s or 28a-f show rmust be notified at	al Director	10e. Street and Number 6 Allan Terrace				10f. Zip Code	078	57	10g. Citizen o	f What Cour	ntry?
<u> </u>	by Funeral	11. Marital Status 1 XNever Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decede Armed Force od 1 □ Yes 2 If Yes, Give Year or Date	is? GNo		Vas Decedent of H fYes, specify Cuba I□Yes 2∑XNo	ispanic Origin? in, Mexican, Puo Specify:	(Specify Yes or North Rican, etc.)	No- 14. Ra Bl Spec	ace - Americ ack, White,	
Maryland 21215-0036 d 2 should be filed within 72 hours all the and Mental Hygiene. 27 is marked other then "neturel; or treumatic event, the Medical Evani	Completed	15. Decedent (Specify only highes: Elementary/Secondary (0-12)	Grade completed) College (1-40	or 5+)	(Give life. L	lent's Usual Occup kind of work done of DO NOT use retired ress / Bart	during most of w i)	rorking	16b. Kind of	Business/Ind	,
and 2 d be filed a sental Hygic	o Be	12 17. Father's Name (First, Middle, L Theadoire Wargo	ast)				18. Mother's N	ame (First, Midd net Switek			
Mary ind 2 shoul alth and Me 127 is mark or treumati	Ĕ	19a. Informant's Name/Relationsh Janet Rosequist /				g Address (Street)				n, State, Zip	Code)
Baltimore, bermit. Pages 1 ar Department of Hea mportant: If item any injury or other pince.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Sp		cen	netery, cren	sition (Name of natory or other plac renatory	June 4, 2	Date 2004	20c. Location	n - City or To altimor	
Balt permit. Departr Importa		21. Signature of Funeral Service L	icense Victor I	P. Doda,	un	Name and Address arles L. St Ol East For	evens Fur	neral Home Baltimor	, Inc. e MD 2123	00)	
ficate be executed ficate be executed was physician and surface is the burial-transit		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a conseque	ince of);	tion(Hero	oin,Coca	ine,andl	Cstasy)		Onset and Death
Geath certif	hyslclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yps 2 ☐ No 9 ☐ Unknown		2 Fetal d at time of dea	eath 3	Ectopic pregnancy Other (specify)				ate of delive	ry Day Year
Records, P.O. The law requires that the ten has been signed by the page 2 should be detach.	by P	Part II. Other significant condition	s contributing to death	n but not result	ing in the ur	derlying cause give	en in Part I.				e cause of death? ably 4 🖃 Unknown
Division of Vital Records, tor Attending Physician: The law requires tafter death. Director: After this certificate has been signed in by the funeral director, page 2 should be on the contract of the contra	e Completed	25. Was case referred to medical					OC Pleas of D	24a. Wa autr pen Yes	formed? 2 \(\text{No} \)	death?	osy findings available pletion of cause of 2 No
of VI Physicia this cer al direct	To B	examiner? 1 X Yes 2 □ No	Hospital: 1 Inpa	atient 🌠 El	P/Outpatient	3 □ DOA Othe	ar.	Home 5 Res		her (Specify)
DIVISION Of VITAI References to the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Haminide	6/1/04	Day Year)	8b. Time of Injury Inknow e, farm, stre	28c. Injury Work n 1 -	vat ⟨? Yes 2 X No	Unknov			Route Number
Divisit To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying	Home Physician: To the be	etc. (Specify) st of my knowl	edge, death	occurred at the tim	e, date and place	Abingdo	on, MD cause(s) and m	anner as sta	Route Number 11te Oak]
thin 24 the 54 the 54 mplete	Medical	29b. Signature and title of fertifier	xaminer: On the basis and manner	stated.	a.iu/UF INV	29c. License		Juried at the time	29d. Date sign		
7.37.8) Clas	Kemo	f donth /ltow 0	(20) (T '	(O.C.M.E.		June (
	ate	30. Name and address of person w	to mo	f death (Item 2 strar's Signatur	111	Penn Str	eet, Ba	Ltimore,	Marylar	nd 212	01
Regist		JUN 0 9 200	ASA.	1715	Coort	وع					

				State of Maryland / Department of Health and N 1- State Registrer Certificate of Death		giene 2	004	182	213
		Physici		1. Decedent's Name (First, Middle, Last) Ralph H. Warner	2. Date of Dea Month	Day	Year	3. Time of I	Death M
1		/Medic Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. Coun	2004 ty of Death	4:00	-
		Funeral		5. Social Security Number 06. Sex 7. Age (Infyrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birt	BA		ORE ce (State or	r Foreign
		Director		408-07-9196	oct.24,	1907	9. Birthpla Countr Tenne:	ssee	
		aryland show	_	10a. State 10b. County 10c. City, Town or Location			100	d. Inside City	
		with the Marylar e or 28e-f show	Director	Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code		10g. Citizen o	f What Countr	1 🗆 Yes	25/2 No
		ath with		11 Runway Court 21220		U.S.A		, .	L.
IER	920	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "neturel", or Items 23e or 28e-1 show eumatic event, the Medical Examinar must be multified at	by Funeral	11. Marital Status 1 □ Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Sive Year or Dates: 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerton Procest) 14. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 16. Yes, Sive Year or Dates:	pecify Yes or No- Rican, etc.)	14. Ra Bl	ace - America ack, White, et ify: Wh:		
WARNE	21215-0036	vithin 72 ho ne. hen "netur e Wedical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) Machinist	king		Business/Indu	stry	
3	1d 21	be filed w tal Hygie d other ti	Be Col	2 Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle,	Aero-	-		
	Maryland	d 2 should by th and Menta 7 is marked treumatic ev	ToE	Hair Hiram Warner Effie A					
7	2	and 2 sh ealth and m 27 is n	l	19a. Informant's Name/Relationship (Type, Print) David P. Warner (Son) 19b. Mailing Address (Street and Number or Rull 1223 Fuselage Avenue,				,)
8410	altimore,	Pages 1 nent of H ant: If ite		20a. Method of Disposition ***SBurial 2 Cremation 3 Removal from State ***4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Mem. Gardens June	Date 11,2004		- City or Tow r, Mary		
(X.	Balt	permit. Departn Importe any inju	1	21 - Fratur F - 1 Ta Barvice Licensee 22. Name and Address of Facility Bruzdzinsk 1407 Old Eastern	i Funera Avenue.	l Home	, P.A.	and 21	1221
_		T ET		23a. Part Thier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory are	rest,	I A	pproximate nterval Betw Inset and De	reen
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of):					
		Examiner	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
	8760,	ate be executed thysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Unionitying Cause (Disease or injury that initiated events resulting in death) Last b. TWEW MONTA: Due to (or as a consequence of): c. Due to (or as a consequence of):					
	P.O. Box 68	To the Hospitel or Attanding Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			ate of delivery	ay Ye	ear
		w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use cor es 2 □ No	ntribute to the		eath?
	Vital Records,	n: The law re ficate has bei r, page 2 sho	e Completed			med? 2.X.No	Were autops prior to comp death?	letion of cau	vailable use of
	of Vit	Physicien: This certificated director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Hospital:	h <i>Check onI or</i> ome 5 ☐ Resido		her (Specify)		
X	Division o	Attending Ph death. ctor: After thi y the funeral	Certification:	27. Manner of Death 1 SNatural 5 Pending 2 Accident investigation 1 Could get be	28d. Describe ho	ow injury occu	rred		
	Divi	el or Att	ertifle	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Si City or Town	treet and Num n, State)	ber or Rural P	loute Numbe	er,
		To the Hospitel or Atwithin 24 hours after d To the Funerel Direct completely filled in by	Medical C	29a. Certifier (Check only one) 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cred at the time, d	ause(s) and m ate and place,	anner as state, and due to the	e cause(s)	
•		To the To the comp	W	29b. Signature and title of certifier PRES 000C		9d. Date signe	ed (Month, Da	y. Year)	
		D		30. Name and address of person who completed gause of death (Item 23a) (Type, Print) Die John NN ALXANDER 9000 FRANKLIN SOUADED.	0 R.17	i wa a M =	MI	117	77
	E	Sta Registr		30. Name And address of person who completed fause of death (Item 23a) (Type, Print) DR Johnny Alexander 9000 Franklin Souare D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature	N DAIL	MORE	7.101	0120	2/

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

						Certificate of Death				Reg. No. 2004 18214			
H	Physici	an	Decedent's Name (First, Middle, La					2. Date of Dee Month	Day	Year	3. Time of Death		
	/Medic		George	Preston	Willi			June	1, 200		6:05 PM		
П	Examin	er	4a Fecility Neme (If not institution, give				4b. City, Town, or				.		
-	Formula	-	Williamsport 5. Social Security Number 6.5		me s. last birthday) If U	Jnder 1 Year	Williar If Under 24 Hrs	8 Date of Birth	1	hing			
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 (Inder 1 Year Months Days Hours Min. 214-09-3088										
	wor.	by Funeral Director	10a. Stete 10b. County	10c. (City, Town or Location	n				10	d. Inside City Limits		
	tha Mary 28a-f st notified		Maryland Wash	ington	Hagerst	OWN of, Zip Code			10g. Citizen of	What Count	1 ☐ Yes 2 No		
	h with	<u> </u>	19921 Trengai	l Road		217	42		U.S		,		
	- dea	iner	11. Maritel Status	12. Was Decedent Ever in Armed Forces?	U,S. 13. Was [Decedent of H	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No-	14. Rad	ce - America			
21215-0020	be flied within 72 hours after death with the Maryland ntal Hygiena. No other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 No Give		es 2X No		o rican, etc.)	Specify				
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Maryland	2 should end Man is marke aurmatic	ဥ	19a. Informant's Name/Relationship (dress (Street	and Number or Ri		yfiel		Shilling		
	C1 0 00 00		Eileen W. Sou		ter 300						-		
ē,	of Health item 27 i	Ì	20a. Method of Disposition	20b.	Place of Disposition cemetery, crematory	(Name of		Date Date	20c. Location -	City or Tow			
Baltimore,	8 = = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 🖾 Other (Specification 5 🖾 Other (Specification 5)	JRemoval from State v) Entombment			,	06-04-0	A Hane	ret ow	n, Marylan		
alti	mit. Pa partmen sortant: / injury		21. Signature of Funeral Service Licer		22. Nan	ne and Addre	ess of Facility Coffman	#000000	i nage	TOCOM	i, maryrain		
Ω	Dep d man		P. hood	Brader	40 E	ew κ.	ntietam S	troot "	Home, 1	nc.	d 24740		
	THE ST		23a. Pert1. Enter the disease, or comshock, or heart failure. List only	plications that of used the de-	ath. Do not enter the	mode of dyir	ng, such as cardia	or respiratory arr	est,		d. 21740 Approximate		
The same	Physician		SHOCK, OF HEART TAILUTE. LIST ONLY	one cause out acti line.						1	Interval Between Onset and Death		
	/Medical		Immediate Cause (Final disease or condition resulting in death) a. LUNG CAUCER - MESOTHELI OMA 3 MONTHS										
	Examiner		resulting in deeth)		(or as a consequence								
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	and al-tran	Examiner	Sequentially list conditions, if eny, leading to immediate	Due to	(or as a consequence	e of):							
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Cause. Enter Ordering Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):] F					
×	anding use	2		d									
Bo	death e atte	SCIB	Part II. Other significant conditions of	rlying cause given in Part I. 23b. Di			id tobacco use contribute to the cause of death?						
P.0		F							1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknow				
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of	£ £ =		27. Menner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injun		28d. Describe ho					
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	tal or rs aft al Dii led in	Š							TOWN, State)				
	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the fi	20	29a. Certifier 1 Certifying Ph	ysician: To the best of my kn niner: On the basis of examin	owledge, death occu- ation and/or investiga	rred at the timation, in my or	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and ma ate and place, a	nner as stat	ed. he cause(s)		
	ithin 2 the on the	_	one) 29b. Signature end title of certifier	and manner stated.		29c. License			9d. Date signed				
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	\cap	-	30. Name and eddress of person who	completed cause of death (Its	m 23a) (Tuna Drint)	D33	>100	7	JUNE 1	, 200	74		
	1		TED E. HOWE	154 N. ARTI		EET U	MULAMS	DODT A	D Z	1795			
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	State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No. 2004								18215				
			Registrar			Certi	unicate of Death		2. Date of Dea	leg. No.	U T	3. Time of Death	
т	Physici	cal	1. Decedent's Name (First, Middle, Las	0			WALL	ACE	Month	Day	Year	1.25 AM	
	/Medic		MARGARET 4a. Facility Name (If not institution, give	stroot and number				or Location of Deat	h	4c. County	of Death	1.23	
	Examin	er	GOOD SAMARI					LTIMOR		40. County	or Dodni		
		7. 7	5. Social Security Number 6. Se		SPITAL		If Under 1 Year	If Under 24 Hrs	8. Date of Birtl	1	9. Birthp	lace (State or Foreign	
Ш	Funeral Director			□ M 2 XX	83	Yrs.	Months Days	Hours Min.	MAY 1, 1	921	VIRG	ÍNIA	
7			Usual Residence of Decedent										
9	how		MD BALT	10c. City, To	10c. City, Town or Location WHITE MARSH					1	0d. Inside City Limits 1 ☐ Yes XX No		
2	8a-f.	Director	HD BALL										
4	Or 22	Dire	10e. Street and Number		10f. Zip Code 10g. Citizen of V				What Cour	itry?			
4	whin /2 nou's after death with the maryland ene. Than "naturel", or Items 23e or 28e-f show the Modical Exeminar must be nutified at		75 WILLOW PATH COURT			10.14	21236 Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			USA	A	on ledina	
		une	11. Marital Status	Armed Forces?	1 ☐ Yes 2 ☐ XXXO If Yes, Give		es, specify Cub	an, Mexican, Puer	to Rican, etc.)	Blace	e - Americ ck, White,	merican Indian, hite, etc.	
36	is all	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			Yes XX No	Specify:		Specify		The second	
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a	Ment Ment arked	2	WILLIAM HOWARD	RANSON				HAZEL /	INCELL				
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ore	permit. Pages 1 and 2 should be filed within 7.2 flouts after death with the marylar Department of Health and Mentlar Hygiene. Important: if time 27 is marked other than "naturel", or Items 23a or 28a-f show eny injury or other treumatic event, the Modical Examinat must be nutified at QDCs.		20a. Method of Disposition XX Burial 2 ☐ Cremation 3x3	Removal from State	cemei	tery, cremat	tory or other pla			20c. Location -			
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	4		30. Name and address of person who		-								
			ZEEBA MATHEN	15,560	rar's Signature	RAVI	ENBL	ID, BA	LTIMORE	, MD	-21	237	
	Sta Regist		31. Date filed MNh. gagYe2004	Terrie	July India (all a)	9 19	ones	,					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 2 2004 0038M JUN 10111Am /Medical 4c. County of Death Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner HUNA POLIS
If Under 1 Year | If Under 24 Hrs. 8 undel Age (In yrs. last bithday, ial Security Number 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours XXX M 2 ☐ F 64 Yrs PARKÉRSBURG, WV Director 300-34-5216 12/1/1939 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County is than "natural", or items 23s or 28s-f show the Modical Examiner must be notified at MXYes 2 □ No 0H LITTLE HOCKING Director WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1088 CORNES ROAD 45742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Vyes 2 □ No Yes, Give 'ear or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify WHITE Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OPERATING ENGINEER LOCAL #132 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental ant: If item 27 is marked o RACHEL McDONALD DELMOND WILCOXEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) RHONDA WILCOXEN - WIFE 1088 CORNES ROAD, LITTLE HOCKING, OHIO 45742 or other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State JUNE 7 2004 ROCKLAND CÉMETERY permit. Page Department of Important: If any injury or once. BELPRE, OHIO ⁴ □ Donation 5 □ Other (Specify) 21. Signatur Ti uneral Service Lic e MARYLAND MORTUARY SUPPORT 22. Name and Address of Facility #M01148 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner rterioscleratic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) use as the burial-transit The law requires that the death certificate be executed abetes resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 Yes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2ALNo 1 ☐ Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2ER/Outpatient 3□ DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No r death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🗆 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) iilled in by 4 - Homicide 1 🚅 certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 25 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier Deputy 29d. Date signed (Month, Day, Year) and address of person who con ted cause of death (Item 23a) (Type, Print) ONES, MD 1 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 0 9 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year JUNE 8, 2004 **JOHN** 4:30 A 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 364 DREW STREET **BALTIMORE** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Yrs. 213-10-3478 87 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits XX Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **364 DREW STREET** 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married XXes 2 No 1940-1 ☐ Yes 2**XX**No WHITE Specify 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry ly highest grade completed) College (1-4or 5+) (0-12)MAIL CARRIER US POSTAL SERVICE

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Exami After this Certification: Director:

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: hours after death. within 24 hours a To the Funeral D Medical

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	Be Con	17. Father's Name (First,
	To B	ADAM J. WAL
		19a. Informant's Name/F
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		20a. Method of Disposition
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	Ö	25. Was case referred to
	0	examiner?
	.0	1 ☐ Yes 2√√No

27. Manner of Death

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

DAVID

31. Date filed (Month, Day, Year)

1 XXNatural

medical

5 Pending

investigation

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SILVER DO

6 Could not be determined

1 🗌 Inpatient

28a. Date of Injury (Month, Day Year)

Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) .TERS THERESA AUGUSTYNIAK Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 364 DREW STREET, BALTIMORE, MARYLAND 21224 RESA HENDRICKSON (SISTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State emation 3 Removal from State Other (Specify) GLEN HAVEN MEM. PARK 6/10/2004 GLEN BURNIE, MARYLAND Service Licensee 22. Name and Address of Facility FINK FUNERAL HOME, PA CORY FINK #M01148 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 r cm, ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List on , one cause on each line. Approximate Interval Between Onset and Death vears Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery nant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy 4□Pregnant at time of death 5 Other (specify) 9 Unknown conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Tes XX No

3 DOA

28c. Injury at Work?

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

26. Place of Death Check only one

Other: 4 Nursing Home 5XXResidence 6 Other (Specify)

Av, Baltimore

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

350

32. Registrar's Signature

28b. Time of

Medical Examiner Substitution	Physic	ian	Decedent's Name (First, Middle,	DCT CCT	T. Wil				2. Date of I	Da	ay	Year	3. Time of Death
BAYTEM MEDICAL CENTER Proceeding	/Medi	cal	Bertel T. Wi				45 Oit Town						16:00
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Use a Reduction of December 100. Control 100.				5. Sex 7. Ag			If Under 1 Year	If Under 24 Hrs	8. Date of E	Birth Day, Year 7 / 20	04	Count	TY)
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Registrar

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	Physic		1. Decedent's Name (First, Middle, La Mary Anne And				2. Date of Death Month May 25,	Day 2004	Year	3. Time of Death 1:45 A
1	/Medi Examii		4a. Facility Name (If not institution, giv	· ·		4b. City, Town, or Lo	cation of Death	4c. County	of Death	
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	with the	Director	10e. Street and Number 6809 Fulfor	d Stroot	10f. Zip Code	20735	10g.	Citizen of W		
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	. 13. Was Decedent of	ZU733 f Hispanic Origin? (Spe Joan, Mexican, Puerto I	cify Yes or No-	14. Race	d Sta	n Indian,
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. "Important: if item 27 is marked other then "natural", or items 23e or 28e-f show any Injury or other traumatic event, the Madical Examiner must be recitied at once.	by Fu	1 ☐ Never Married 2\(\frac{1}{M}\)Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ № o If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ N		Rican, etc.)	Specify:	k, White, etc	
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ylar	2 should be and Mental I is marked of aumatic eve	2	James C. Waddel				rothy A.			
	and 2 sh salth and n 27 is m		19a Informant's Name/Relationship (7 George Lurence A		19b. Mailing Address (Streemd) 6809 Full:	et a <i>nd Numb</i> er or Rure. ford Street	Route Number, Cit. Clintor	ty or Town, s n. Mar	Stete, Zip $lpha$ v 1 and	ode) 20735
Baltimore,	es 1 and 3 of Health item 27 i		20a. Method of Disposition 1. A Burial 2 ☐ Cremation 3 ☐	20b. Pla	ce of Disposition (Name of netery, crematory or other p			Location - 0		
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	to the respital or handing Physician: The is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	edicai	29a. Certifier (Check only one) Certifying Phy 2 Medical Exami	siclan: To the best of my knowle ner: On the basis of examination and manner stated.	dge, death occurred at the to and/or investigation, in my	ime, date and place, an opinion, death occurred	d due to the cause(I at the time, date a	(s) and manr nd place, an	ner as state d due to the	d. e cause(s)
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1	315		30. Name end address of person who a Louis Kaufmann,			Woldonf	Manu 1 and	20602		
30	Stat	е	31. Date filed (Month, Day, Year) MAY 2 7 2	32. Registrar's Signature	L Land	, waluori,	raryrano	40002		

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within 24 hours after death. To the Funeral Director:

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To the Hospital or Attending Physician: The law requires that the death certificate be executed

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Hygiene.

P.O. Box 68760. Division of Vital Records, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? 18221 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Year Emmitt William Askew May 13, 2004 2029 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 7, 1934 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 12XM 2□ F Yrs Director 238-56-8769 69 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 Timber Ridge Dr. 21157 USA Apt. 201 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 XNo 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify þ 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Artist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Emmitt L. Askew Clara Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 Leeanne Rd. Sister Baltimore, MD <u>Susan Heil</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【③Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/18/04 Hampstead, Maryland Carroll Cremation Inc 21. Signature of Funeral Service Licens 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21157 412 Washington Rd. Westminster, MD of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part. Enter the diseese, or complications that shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) encephalopaty Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physiclan/Medical Examiner Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 300 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes >No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 23 443 1 opmale 5/14/04 west minster 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NAYAN VAYWALAMD 1130 Baltimore Blvk VAYWALAMD 1157 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2004 Glown & Spark Registrar

		- State Registrer			Maryland	Cei	rtificate	e of l	Death			Reg. N		U 14	1822
Physicia	an	Decedent's Name (First, Min								2.	Date of I Month	D		/ear	3. Time of Death
/Medic	al .	ALMA DELORES									MAY	25,			12:45 P ^M
Examin	er	4a. Facility Name (If not institu 36PINEWOODS E		and numbe	r)				Location of			4	c. County of		
		5. Social Security Number	6. Sex	7.4	Age (In yrs. la:	st hirthday)	MT .		E PARK		Date of I	Ridh	GARR		on /State as Faurin
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Department of Health a Important: if item 27 is any injury or other traignes.	1	21. Signature of Funer Sarvi	Licensee	1		22	. Name and	d Addres	s of Facility		P.O.	BOX	243		
25 29		Hours 14	We	رب	M0016	57 DI	JRST I	FUNE	RAL HO	ME -				1550	
		23a. Part1. Enter the disease, shock, or heart failure. L	or complication	s that cause se on each	ed the death. line.	Do not ente	er the mode	of dying	g, such as ca	ırdiac or re	spiratory	arrest,		li A	opproximate nterval Between
ysician -		Immediate Cause (Final disease or condition		ADEN	NOCARCI	NOMA	OF UT	rerii:	S W/M	TETAST	ΓΔΩΤΩ				Onset and Death
ledical		resulting in death)	a		s a conseque				,					110	DIVITIO
aminer		Sequentially list conditions,	b												
i.	ne l	* any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1	Dua to (or a	s a nonseque	nea of):									
and -trans	Examiner	that initiated events resulting in death) Last	c	Dun to (or or											
physician and s the burial-transit	m m	,	,	DOS TO (OI A:	s a conseque	nce or):									
physi the t	edicai		d								-				
OD 48	₩	IF FEMALE:	23c If v	es outcom	e of pregnanc	v						====			
attending tor use as	ian	23b. Was decedent pregnant in the past 12 months?	10	Live birth	2 Fetal de at time of deat	eath 3	Ectopic pre						23d. Date o Month		ay Year
ched	ysic	1 □ Yes 2 ဩ No 9 □ Unknown		Unknown	at tillie of deal	m 5C	Other (spe	city)				100			
ed by deta	by Physician/M	Part II. Other significant cond	itions contributing	ng to death	but not resulti	ng in the ur	derlying ca	use give	n in Part I.		23e. Did	tobacco	use contribu	ite to the	cause of death?
n sign	D D										1	Yes 2	[X]No 3[Probab	ly 4 ∐Unknowr
been signed by the attendir should be detached for use	Completed									_	24a. Wa		24h Wor	o autono	y findings available
has 99 2	ᇍ									_	aut	opsy formed?	prior	r to comp th?	letion of cause of
m (n)	ပ္မ	25. Was case referred to medi	aal								1 🗆 Yes	2 🛛 No	1 🗆	Yes 2	□ No
flicate or, pag		examiner?	Hospita	:	ient 2 EP)/O		Othe	26. Place of				-36	T	A HOUTED!
certiticate irector, pag	ω ∣	1 □ Yes 2 W No		Date of Ini	urv 28	Bb. Time of		c. Injury Work	4 Nursi	_			f Al Other (Specity)L	AUGHTER'
his certition	2 B	1 ☐ Yes 2 🔯 No 27. Manner of Death	28a	(Month Da	ay Year)	Injury	м		? ′es 2.⊡No			•	,		
Atter this certitin funeral director	2 P	27. Manner of Death 1X Natural 5 ☐ Pen		(NOTION, DE											
Atter this certiting funeral director.	2 P	27. Manner of Death 1 Natural 5 Pen 2 Accident inve 3 Suicide 6 Cou	ding stigation ld not be	Place of In	jury - At home	ə, farm, stre	et, factory,	office		28f.				or Rural F	loute Number,
irector: Atter this certition by the funeral director.	2 P	27. Manner of Death 1 Natural 5 Pen 2 Accident inve	ding stigation	Place of In	njury - At home ntc. <i>(Specify)</i>	ə, farm, stre	et, factory,	office		28f.		(Street ar own, State		or Rural R	loute Number,
irector: Atter this certition by the funeral director.	Certification; To B	27. Manner of Death 1 Natural 2 Accident Accident 3 Suicide 6 Cou dete	ding stigation Id not be mined 28e	Place of In building, e	t of my knowle	adge death	occurred a	t the time	e, date and p	lace and	City or To	own, State) and manne	ar ac ctat	ad.
irector: Atter this certition by the funeral director.	Certification; To B	27. Manner of Death 1 Natural 2 Accident Accident 3 Suicide 6 Cou dete	ding stigation ld not be mined 28e lying Physicien: al Exeminer: Or	Place of In building, e	t of my knowle	adge death	occurred a	t the time	e, date and p inion, death	lace and	City or To	own, State) and manne	ar ac ctat	ad .
rs arter deam. rel Director: Atter this certition by the funeral director.	edical Certification; To B	27. Manner of Death 1 Natural 2 Accident inve 3 Suicide 6 Cou 4 Homicide dete 29a. Certifier Check only 2 Medic	ding stigation id not be mined 28e ying Physicien: al Exeminer: Or an	Place of In building, e	t of my knowle	adge death	occurred a estigation, i	t the time	inion, death	lace and	City or To	own, State cause(s , date and) and manne	er as state due to th	ed. e cause(s)
irector: Atter this certition by the funeral director.	edical Certification; To B	27. Manner of Death 1 Natural 2 Accident inve 3 Suicide 4 Homicide 29a. Certifier (Check only one)	ding stigation id not be mined 28e ying Physicien: al Exeminer: Or an	Place of In building, e	t of my knowle	adge death	occurred a estigation, i	t the time	number	lace and	City or To	cause(s , date and 29d. Da	and manne d place, and	or as state due to th	ed. e cause(s) y, Year)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MAY 20, ^{Day} 2004 Year **Physician** 1:00 PM BOONE ROY LYNN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WESTMINSTER CARROLL LOOKABOUT MANOR If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 9. Birthplace (State or Foreign Country) VEST VIRGINIA 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9 / 27 / 1911 5. Social Security Number **Funeral** M 2□ F 217-28-5945 92 Yrs. WEST Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No CARROLL TANEYTOWN Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö USA 21787 5030 BABYLON RD. or Items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritat Status filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygiens Important: If Item 27 is marked other than any injury or other traumatic event, I.a. 2008. AGRICULTURE FARMER 3 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) BOONE FRANCES SWISHER WILLIAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30400 NORWICH DR., NOVI, MICHIGAN ROXANNE BOONE - DAUGHTER 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State ALL COUNTY CREMATION 5/21/04 SYKESVILLE, MD. ' 4 □ Doylation 5 □ Other (Specify) A) e al ser ce Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 21. Signal 254 E. MAIN ST., WESTMINSTER, MD. 21157 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MUEN LANS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9☐ Unknown N/X. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 Probably 4 Munknown 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No certificate has t irector, page 2 s or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other Specify Line (1)} \) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 Yes 2N No Certification: To this To the Hospitel or Attending Phys within 24 hours after death.
To the Funerel Director: After this completely filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🕵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number WJ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. RUZBARSKY, MD 125 AIRPORT DR.#34, WESTMINSTER, MD. 31. Date filed (Month, Day, Year) MAY 2 1 2004 32. Registar's Signature Boom & fresh Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. SHirley Mae Bosley State of Maryland / Department of Health and Mental Hygiene 04 - 3382State Registrar Reg. No. 2004 Certificate of Death AKG 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day SHIRLEY MAE BOSLEY 19, May 2004 22:33 P^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Hospital Center Westminster

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State Months | Days | Hours | Min. | MAY | 19, 1934 | MARYLAND Westminster 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2√2 F Director 215-32-8881 70 Yrs. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-1 show 10a State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits MD. Completed by Funeral Director CARROLL WESTMINSTER 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 2 Irer must be n 2806 MANCHESTER RD. 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic event, the Medical Examiner Black, White, etc. 1 Never Married Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 ASSEMBLY LINE MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GARLAND LEE BOLLINGER VIRGIE MAE COE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARION F. BOSLEY -HUSBAND 2806 MANCHESTER RD., WESTMINSTER, MD.21157 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of h Important: if ite any injury or ot once. 1

Burial 2

Cremation 3

Removal from State ZION CEMETERY 5/24/04 * 4 ☐ Donation 5 ☐ Other (Specify) FINKSBURG, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical ue to (or as a conte uence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 See 2 □ No 24a. Was an autopsy performed? Yes Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 **XX**es 2 ☐ No 1 🔲 Inpatient 2☐ER/Outpatient 3☐ DOA this $\times H \mathcal{M}$ | Certification: T 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred of comptune 28b. Time of Injury 1 Natural 5 Pending HM 5-19-04 death. 2 Accident 3 Suicide 9:47 AM investigation 1 ☐ Yes 2 No rich after death the on passenger 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Northber or Rural Route Number of Town, State) 4 Homicide filled in 24 hours a Washinster 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho

To the Fune

completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title 29c. License number 2 29d. Date signed (Month, Day, Year) WIL O.C.M.E. May 20, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) State Registrar Blown & Specie 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM #25, 26,220 of Maryland Bepartment of Health and Mental Hygiene For Amend Item #18

For Amend Item #18

For Amend Item #18

Certificate of Death

Reg. No. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** Harry W. Burger 14 2004 9:15 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Holly Place 268 South Potomac St Washington Hagerstown If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. XX M 2□ F 93 Director 4/25/1911 220-10-3155 Pennsvlvania Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23e or 28a-f show any injury or other traumatic event, Tra Modical Exarcitives over the notified at once. 1. Yes 2 □ No Funeral Director MD Washington Hagerstown, 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 268 South Potomac Street 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify White 2 3 ⊠ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Laborer RECYCLING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ethel May Shatzer Bertha Rines Clarence Burger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13717 Village Mill Dr. Maugansville MD 21767 Viola Manspeaker/ Neice 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 5/18/04 Smithsburg Crematory 22. Name and Address of Facility Rest Haven Funeral Chapel Smithsburg, Maryland ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligensee 1601 Pennsylvania Ave. Hagerstown Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Enysician** /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events signed by the attending physicien and doe detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Division of Vital Records, P.O. Box 68760 4 years. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes After this certification To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be assisted Other: 4 Nursing Home 5 Residence ** ther (Specify) living 1 ☐ Yes XXNo 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Natural 2 Accident 5 Pending 2 🗆 No death. investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funeral Direct completely filled in by filled in by 4 T Homicide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of symmination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 6/08/04 erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of 35 עו מע State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 DUL 1. Decedent's Name (First, Middle, Last) 2 Dete of Deeth **Physician** Month May 200ar Ellen Virginia Banzhoff 6:05 AM /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Williamsport Nursing Home Williamspor.

If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Dey, Year)
May 14, 1921 Williamsport Washington 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country)
 Mary land 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2XXF Director 212-24-5928 83 Yrs. Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haaith and Mental Hygiena. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any fulury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director XXYes 2 No Maryland Washington Williamsport 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 202 S. Artizan Street 21795 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 CNo If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Maritel Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Merried 3altimore, Maryland 21215-0020 1 ☐ Yes 2√CXNo Specify: Completed by Specify: 3ŒWidowed 4 □ Divorced White 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Inspector Hosiery Manufacturer 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Thomas Hose Gwendola 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 127 S. Artizan St. Williamsport, Maryland Rosalie E. Bennett - Daughter 21795 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Lawn Mem. Park 5-25-04 Hagerstown, Maryland 21. Signature of Fyneral Service Ligenset Osborne funeratiin Home, P.A. 425 S. Conococheague St. Williamsport, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart dilure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) mmediate Examiner Due to (or as a consequence of) mellitu Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest Due to (or as a consequence of) attending physician Completed by Physician/Medical the th Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No 1 Tyes 1 ☐ Yes 2 ☐ No edical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Menner of Death 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending 1 Yes 2 No investigetion 2 Accident

To the Hospital or Attending Physician: The lew requires that tha death certificata be executed Division of Vital Records, P.O. Box 68760. After this within 24 hours after death.

To the Funeral Director: All complataly filled in by the fu

DHMH 16 Rev 6/95

State Registrar 3 Suicide

29a. Certifier (Check only one)

4 - Homicide

29b. Signature end title of certifier

25 2004

Cynthea Kutther - Sando, ND

6 Could not be determined

Cynthia Kutther Sands MD . Williamsport 32. Segistrer's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Natsing Home, ISY North Artizan Street

29c. License number

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

May 22, 2004

Williamsport, Maryland 21795

			i icasc	,,					d Mental Hy		Logibic.	
			For Stete Registrar	State of Wi	arylari		rtificate of		u Memai i iy	Reg. No.	2001	10227
			Decedent's Name (First, Middle, L.)	ast)					2. Date of De	ath	0 0 7	3. Time of Death
	Physicia /Medic		KIMBERLY MICH	ELE BOCK	STANZ				MAY	22 Day	2004	1:30 P ^M
П	Examin	_	4a. Facility Name (If not institution, gi	ve street and number)		-	4b. City, Town, o	Location of D	eath	4c.	County of Deat	h
			9 HOPEWELL ROAD	7.4	- //	land birdbalanı	WILL.	IAMSPOR		-th		NGTON
н	Funeral Director			Sex 7. Ag 1 ☐ M 2 🖾 F	43	last birthday) Yrs.	Months Days		Ain. (Month, Da	3, Year)	960 MA	hplace (State or Foreign untry) RYLAND
			Usual Residence of Decedent						1100. 2	,J, 1	700 IIA	
	arylan show	_	10a. State 10b. County		10c. City	y, Town or Lo						10d. Inside City Limits 1 X Yes 2 ☐ No
	death with the Maryland ims 23e or 28e-f show	Director	MARYLAND WASHI	NGTON			10f. Zip Code	WILLIAM	1SPORT	10a Citi	zen of What Co	
	with t		10e. Street and Number	A DOTT. D			TOI. ZIP CODE	21795		10g. Oili	U.S.	
	death ms 23	by Funeral	9 HOPEWELL ROAD, 11. Marital Status	12. Was Decedent		S. 13.	Was Decedent of H		 (Specify Yes or No uerto Rican, etc.))-	14. Race - Ame	rican Indian,
	or Iter	F	1 ☐ Never Married 2 X Married	Armed Forces? 1 Tes 2 1		1	iYes, specify Cuba 1 □ Yes 21XINo		uerto Hican, etc.)		Bleck, White	e, etc.
003	be filed within 72 hours after death with the Marylan hal Hygiene. Id Hygiene. Id other than "neturelt, or Items 23s or 28s-1 show event, the Medical Examiner must be trufflied at	d b	3 Widowed 4 Divorced	Year or Dates:						10) 10	W	HITE
15-	n 72 h "netu	Completed	15. Decedent's I (Specify only highest g	rade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of	working	16b. Ki	nd of Business/	Industry
212	within liene.	ошь	Elementary/Secondary (0-12)	College (1-4or	5+)		DISAB	LED			DISAB	LED
פָ	be filed within tal Hygiene. Id other than '	Bec	17. Father's Name (First, Middle, Las	it)				18. Mother's	Name (First, Middle	, Maiden	Sumame)	
ylaı	should by ad Menta marked matic ev	To	MERLE FRANKLIN W	HIPP SR.					BOHRER			
Maryland 21215-0036	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic	5	19a. Informant's Name/Relationship				•		r Rural Route Numb			
	s 1 and if Health item 27 other t		WAYNE K. BOCKSTA 20a. Method of Disposition	NZ/SPOUSE	20b. P	lace of Dispo	sition (Name of		C. B, WILI		cation - City or	
nor	8 = 5		1 ☐ Burial 2 【XCremation 3 `4 ☐ Donation 5 ☐ Other (Spec			•	matory or other plac	1	5/26/2004	CMI	TTUCDIDA	G. MARYLAND
Baltimore,	- 트립글		21. Signature of Juneral Service Lice			2:	RG_CREMAT 2. Name and Addre	ss of Facility	7606 0		itional	
ä	Depar Depar Impo		() CO	Kelly A. Z	Zimmer	man B	AST FUNER	AL HOM	H'		Marylar	
			23a. Part 1. Enter the disease or con shock or hear failure. List on	mplications that caused y one cause on each li	d the death	n. Do not en	er the mode of dyin	ig, such as car	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
E	Pnysician		Immediate Cause (Final disease or condition	a. Carde	ores	nera	tony ar	rist	inmed	eat	8 4	inneliate
П	/Medical Examiner		resulting in death)	Due to (or as			\mathcal{O}_{r}	/				2
		e e	Sequentially list conditions,	b. Due to (or as	a contegu	uence of	Clari	den				20915.
	uted d ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	С.								
o,	be execuriclan and burial-tra		resulting in death) Last	Due to (or as	a conseq	uence of):						
8760,	0 %	dical	•	d								
x 68	death certifical e attending phy d tor use as th	/Me	IF FEMALE:	23c. If yes, outcome	of pregna	incv					23d. Date of deli	iven.
Вох	atten atten	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	I death 3	Ectopic pregnancy Other (specify)	<i>'</i>		1	Month	Day Year
o.	that the death ed by the atte detached tor	Physician/Med	1 ☐ Yes 2 MaNo 9 ☐ Unknown	9□ Unknown								<u> </u>
o,		by P	Part II. Other significant conditions	contributing to death b	out not res	ulting in the u	nderlying cause giv	en in Part I.				the cause of death?
ord	w requires t been signe should be								- 10	Yes 2	JNo 3∐Pro	obably 4 3 Unknown
Vital Records,	S S	Completed							24a. Was		24b. Were au prior to death?	topsy findings available completion of cause of
al F									1 ☐ Yes	2 No		2 □ No
Zi.		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No	Hospital:	ont 2	EB/Outpatio	nt 3 DOA Oth	00	Death (Check only ng Home 5 Res		S □Other /Sne	264)
of	y Phys er this eral di	-	27. Manner of Death	28a. Date of Inju	ury	28b. Time o			28d. Describe			ony)
ion	ath. r: Att	atlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigati	ion	iy roar,	Injury		Yes 2 □ No				
Division	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		jury - At ho tc. (Specif	ome, farm, st	reet, factory, office		28f. Location (City or To			iral Route Number,
۵	urs at urs at aral D		Continue 150 Continue	Physician Table had	of mulkoo	uulodaa daat	h convered at the tir	me date and n	less, and due to the	201120(2)	and manner on	stated
	To the Hospitel or Attending Pl within 24 hours after death. To the Funeral Director: Attent completely filled in by the funera	edical		Physicien: To the best eminer: On the basis of and manner st	of examina							
	Fo the	Me	29b. Signature and title of certifier				29c. Licens				e signed (Month	
	6		masson	20	In		_	14800			5,24,0	
	bXX		30. Name and address of person when MASSOCIO B.	ACIZADEI	death (Iten	23a) (Type	Print)	2401	Frederic	h s	treet.).
	Sta Regista		31. Date filed (Month, Pay, Year) A 2 4	2004 32. Pegist	rar's Signa	ture G. A	ale					

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

			For	State of Marylan	d / Depa	artment of H	lealth ar	nd Mental Hy	giene 20	04 18229
			1 State Registra MEND ITEM 1. Decedent's Name (First, Middle, La	#5 PER FH G832	6/099	rtuticate of	Death	2. Date of De		3. Time of Death
	Physicia /Medic		Rosert Er	ic Benne	H			April		Year 06:20 PM
	Examin		4a. Facility Name (If not institution, giv	e street and number)	1	4b. City, Town, o	or Location of	Death /	4c. County o	f Death
	Funeral		5. Social Security Number 6. S	AM/AND MOCCAL (Sex) 7. Age (In yrs.	enfl1 last birthday)	It Under 1 Year			th	9. Birthplace (State or Foreign
,	Funeral Director		215-19-2904	1 2 29	Yrs.	Months Days	Hours	OCT . 19	1974	MARYLAND
	land		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. tnside City Limits
	a-f ah	ctor	MD QUEEN A	ANNE'S CH	ESTER					1 ☐ Yes 2 X No
	with the	Funeral Director	10e. Street and Number	. D		10f. Zip Code 21619			10g. Citizen of Wh	nat Country?
	ns 234	eral	236 DOMINION ROA	12. Was Decedent Ever in U.	S. 13.	Was Decedent of H	Hispanic Origin	n? (Specify Yes or No	- 14. Race	- American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28e-f ahow amy righty or other traumatic event, the Medical Examinational be notified at ance.	by Fun	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		It Yes, specify Cub 1 ☐ Yes 2 X No		Puerto Rican, etc.)	Specify:	, White, etc. WHITE
2-0 2-0	72 hou natura	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Give	dent's Usual Occup	during most of	of working	16b. Kind of Bus	iness/Industry
21215-0036	within ane. then	Completed	Etementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire			ENGINE	ERING
<u>5</u>	il Hygi other	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's	s Name (First, Middle	Maiden Sumame)
ylar	Menta Menta arked	ToE	CHARLES R. BENNET					NNE VINER		
Maryland	nd 2 sh lith and 27 is m r traum		19a. Informant's Name/Relationship (CHARLES R. BENNET					or Rural Route Numb CHESTER,M		tale, Zip Code)
Baltimore,	of Head of Head fitem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, cre	osition (Name of matory or other pla		Date		city or Town, State
ţi	t. Pag rtment rtant: I		' 4 □ Donation 5 □ Other (Special	(y) STE				4/06/2004		TILLE, MD
Bal	Depar Impol any ir		21. Signature of Funeral Service Lice	efl.		06 SHAMRO	CK RD.	, CHESTER,	MD 216	
В			23a. Part1. Enter the disease, or com shock, or heart tailure. List only	plications that caused the death one cause on each line.	h. Do not en	ter the mode of dyid -	ng, such as ca	ardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Closeo He.	40 LN	ansh				1 DAY
	Examiner		Sequentially list conditions,	o MotonVehicl	e Coll	ISLON				
	led nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or intury	Due to (or as a conseq	uence ot):	= 1	CERTIFICATION			
ó	execu en and rial-tra		that initiated events resulting in death) Last	C. Due to (or as a conseq	uence ot):		21	APPROVED BY MEDIC	L EXAMINER	
8760,	law requires that the death certificate be executed so seems signed by the attending physicien and 2 should be detached for use as the burial-transit	dlcal		d			_ 0/0	~ m eff	{ `	
9 X	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date	ot delivery
Box	death e atter	Physician/Med	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		□Ectopic pregnanc □ Other (specify) _	у		Mont	· ·
0	hat the de id by the a detached i		9 Unknown Part II. Other significant conditions		ulting in the u	inderlying cause giv	ven in Part I.	23e. Did t	obacco use contrib	oute to the cause of death?
ds,	juires that n signed t	d by		.				10	Yes 200 No 3	B ☐ Probably 4 ☐ Unknown
Records,	e law requir has ben si je 2 should i	Completed						24a. Was		ere autopsy findings available for to completion of cause of
	The ate h page	Com							rmed? de	ath? □Yes 2□No
Vital	Physician: Th r this certificate ral director, pay	o Be	25. Was case referred to medical examiner? ↑ ★ Yes 2 □ No	Hospital: 1 Inpatient 2	E9/Outpation	nt 3 DOA Ott	200	f Death (Check only of ing Home 5 Resi		(Specific)
Division of	£ = E	-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o				how intury occurred	
side	Attending r death. ector: Itel	catto	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	in MARCH 22, 2009	9:00	A M 1	Yes 2 12 No			mier ribitle seems
Divi	5 # 5 E	Certification;	4 Homicide determined		ome, tarm, st	TOWA	\/	City or To	street and Number wn, State)	r or Rural Route Number,
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the			hysician: To the best of my kno miner: On the basis of examina						
	the H hin 24 the F	Medical	one)	and manner stated.	COTT ATTOO TO	29c. Licens		occurred at the time,		(Month, Day, Year)
)	T wi		29b. Signature and till.	116/12		DI	777	6	4/01	2004
			30. Name and address of person who	complited Juse of death (Item	n 23a) (Type,	Print)	112		1011	
			TIMOTHY N. MCGLA	UGHLIN M.D., 22	2 S. Gl	REENE STR	EET, B	ALTIMORE,	MD 2120	L
	Sta Registi		31. Date filed (Modify: Day D. Rur)	6 2004 ^{32. Registrar's Signature}	* *	Soule				

State of Maryland / Department of Health and Mental Hygiene 200 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey Year **Physician** Mar 12:55 Pm Theresa Bernard 24 2004 /Medical 4b. City, Town, or Locetion of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Caroline of Health Denton Ruxton Denton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 5. Sociel Security Number 6. Sex **Funeral** Months 1 M 2 T 146-16-2044 March 31,1918 86 Connecticut Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Caroline Denton Completed by Funeral Director 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street end Number 420 Colonial Drive 21629 United States Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. 11. Marital Status 1 DYes 2 □ No If Yes, Give Year or Dates: WWT 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: specify: White 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Poultr E995 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Paradise Benoit EUSEVE 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Shirley Held / Guardian Rd. Chestertown, MD Schauber 100 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremetion 3 □ Removal from State 05/27/04 Federalsburg, 4 ☐ Donetion 5 ☐ Other (Specify) Bloomery 21. Signature of Funeral Service Licensee Funeral Framptom Home, P.A. 216 N. Main St. rederalsburg. 21632 Muhait 23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as dardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of Physician/Medical Examiner or Attending Physician: The lew requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) sere has been signed by the e page 2 should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 € 10 3 ☐ Probably 4 ☐ Unknown VUSI Sa dise este Be Completed by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1LI Yee SERVICE STATE 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 Yes 2√No ursing Home 5 ☐ Residence 6 ☐Other (Specify) Medical Certification: To this 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Naturel s after death.

I Director: After din by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completaly fillad in by 4 Homicide within 24 hours a A Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner stated. 29a. Certifier (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of 30. Name, end eddress of person tho completed cause of death (Item 23e) (Type, Print) 1) Dorch 2 CUP 5007 31. Dete filed (Month, Day, Yeer) 32. Registrer's Signature

DHMH 16 Rev 6/95

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:15 May 2004 рм Charlotte Ahmuty Ba
4a. Facility Name (If not institution, give street and number) _ Bane /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 8/3/28 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF 213-22-1585 Yrs 75 Maryland Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f ahow other traumatic event, the Medical Examiner must be notified at 1 Tyes 2 TYNo Funeral Director Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Cifizen of What Country? 3420 Nova Scotia Road Itams 23a 21001 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 □Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Cotlege (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker In home 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is markad other any injury or other traumatic event ODEs. 18. Mother's Name (First, Middle, Maiden Surname) Samuel Ahmuty, Sr. Charlotte Pratt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shannon Bane (Son) 7 Darlington Rd., Havre de Grace, MD 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Mem. Gdns. 6/2/04 Aberdeen, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furreral Service Licensee 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Priysician CONCESTIVE HEART FAILURE. /Medical Due to (or as a consequence of): Examiner 6FT LOWER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 The law requires that the death certificated Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes □ 2□ No 24a. Was an certificate has performed? 1 ☐ Yes 21110 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral I Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 726191

State Registrar

DHMH 17 Rev 1/2001

CHARLOTTE AHMUTY BANE

SIRITHARA, PUITE 206, 750508LER DRIVE, TOWSON, MD 21204 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barrer & Sparter

			•	For State Registrar	State of Ma	-	epartme Certifica			nd Me		iene _{eg. No} 2 (004	18232
		Physici	2.0	Decedent's Name (First, Middle,							2. Date of Dea Month	Day	Year	3. Time of Death
		Physicia /Medic			Ann Colabuco	:1					May 25			12:20 P ^M
	7	Examin	er	4a. Facility Name (If not institution,		1			r Location of	Death			nty of Death	
					ryland Hospi	LTAL (In yrs. last birt		linto er 1 Year	If Under 2	4 Hrs.	8. Date of Birth		9. Birth	orge's
		Funeral Director		579 90 5221 Usual Residence of Decedent	1□M 2□F		rs. Months	Days	Hours	Min.	Oct 4,	1959_	Cou	hington DC
		/land		10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
		r 28a-f show	tor	Maryland Prince	George's	Camp S	Springs							1 ☐ Yes 2 ☐ No
		with the 3e or 28	Funeral Director	10e. Street and Number 6211 Trueman D	rive		10f. Z	ip Code 20	748		1	Og. Citizen	of What Cou	
		death	nera	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Dec	edent of H	lispanic Orig an, Mexican,	in? (Spec	effy Yes or No-		Race - Amer	ican Indian,
12:20 FM	930 village vi			1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced		£ .		2G No	Specify:	, , , , , , , , , , , , , , , , , , , ,	10011, 010.7	Spe	aif.	White
0	20	72 ho	eted	15. Decedent's (Specify only highest	Education grade completed)	16a.	Decedent's Us (Give kind of v life. DO NOT	ual Occup	ation during most	of working	q	16b. Kind o	f Business/l	ndustry
E8	2121	within liene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+) I	'Me. DO NOT Iousewi:		d)			Homen	aker	
,0	land ?	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natur eny injury or other treumatic event, Ita Madical any injury or other treumatic event, Ita Madical	To Be C	17. Father's Name (First, Middle, L Vincent Gr					18. Mother		(First, Middle, by Hul		name)	
7	lary	2 should and Men is marke		19a. Informant's Name/Relationshi			-				Route Number			
0		and sealth m 27		Diane M. Grind	er (Sister)		Disposition (N		Lane I	Drıv∈				ia 22033
2	Baltimore,	ges 1 t of Hi ff iter or oth		20a. Method of Disposition 1 □ Burial 2 □ Y Gremation		cemeter	y, crematory or	r other plac	1			20c. Locatio		
25	ţ	t. Partmen		`4 □ Donation 5 □ Other (Sp.		Lee (Cremato:					Clint	on, M	aryland
5	Bal	Departiment of the post of the		21. Signature of Funeral Service L	H mm 5	41								663301d and 20735
•				23a. Part1. Enter the disease, or o	complications that caused	the death. Do r							rial y 1	Approximate Interval Between
		Physician		shock, or heart failure. List of Immediate Cause (Final disease or condition		201/6	1/nno	v Ga	Thi	اموما				Onset and Death
		/Medical		resulting in death)		consequence	of):			LEEU				
		Examiner		Sequentially list conditions.	D.	agulo	path	4						
		pe sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	consequence								
		sicien and burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as a	a consequence	u Julu							
	8760,	ate be ex nysicien he burial	calE		d D	DOOR	airw	ay	bleed	lina	·			
	9	tificate ng phys as the				1 7 0	V • • • • • • • • • • • • • • • • • • •			1				
eresa	P.O. Box	ne death cer the attendir hed for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic 5 □ Other (y				Date of deli Month	very Day Year
7	٩	es that thighed by	by Pr	Part II. Other significant condition	ns contributing to death bu	ut not resulting in	the underlying	cause giv	ven in Part I.		23e. Did to	bacco use c	antribute to	the cause of death?
26	rds	quires on sign	ed b	Hypoter	151 On						1 □ Y	es 2. 🗹 🕍 d	3 □ Pro	bably 4 Unknown
-	ecords,	e law requir has been si je 2 should	Completed	Anemia							24a. Was a		b. Were au	topsy findings available ompletion of cause of
. ~	$\mathbf{\alpha}$	The late his	lo E	,							perfor	med? 2 ZNo	death? 1 🗌 Yes	~
U	of Vital	cian: ertifica	Be (25. Was case referred to medical examiner?				04			(Check only or			
5	of V	hysio this co	ို	1 ☐ Yes 2 🔼 No		nt 2 ER/Ou					ne 5 Resid			ify)
\sim		Jing F	lon	27. Manner of Death 1 Natural 5 Pending 2 Accident investig		Year)	rime of njury M	28c. Inju	rk? Yes 2		od. Describe II	ow injury oc	Carred	
olabucc	Division	or Attending Physician: after death. Director: After this certifici in by the funeral director,	Certification;	2 Accident Investig. 3 Suicide 6 Could n 4 Homicide determine	ot be	ury - At home, fa c. (Specify)					8f. Location (S City or Tow		mber or Ru	ral Route Number,
LC C	_	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	edical C		Physicien: To the best of xaminer: On the basis of and manner sta	examination an								
		To th Within To th	Me	29b. Signature and title of certifler	11		2	29c. Licens	se number	_		9d. Date sig	ned (Month	n, Day, Year)
		_		N 4 49	ahiusun	W MI	2)00	52	999	5	125	12004
	(2-		30. Name and address of person v		eath (Item 23a)	(Type, Print)		V 6 4 1	n a	~~	5 h J num A	. 4.1	MD 20725
	J	20K		ALI RAHIM		1501 S ar's Signature	UKKA	171	KUAI	レコ	05 6	11V 1(ו מכ	MD 20735
		St Regist	ate	31. Date filed (Month, Day, Year) MAY 2	7 2004	ars Signature	local	61						

			1 - For State Registrer	State of M	/larylan		artment of I rtificate of			_	-	2001	10000
			Decedent's Name (First, Middle	, Last)			inouto o.	Douth		2. Date of De		004	3. Time of Death
	Physici /Medio		Charles V	Washington	Carr					Month May	Day 23	2004	12:50A M
1	Examir		4a. Facility Name (If not institution	•	•		4b. City, Town,	or Location	of Death	_		ounty of Death	
			Westminster Nu				L	ninste				Carro	L1
	Funeral		5. Social Security Number	6. Sex 7. / 1⊠M 2□F	Age (In yrs. i 94	last birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Bird (Month, Da	th y, Year)	9. Birthp Cour	place (State or Foreign ntry)
	Director		220-09-7848 Usual Residence of Decedent		24	+ 113.				Dec. 1	0 190	9 Mar	yland
	yland		10a. State 10b. County		10c. City	y, Town or Lo	ocation					1	IOd. Inside City Limits
	B-f sl	tor	Maryland Car	roll		West	ninster						1 ☐ Yes 2 🖾 No
	or 28	Director	10e. Street and Number				10f. Zip Code				10g. Citizer	of What Cour	ntry?
	ath w		1234 Washingto	on Ave.			2115					ed Stat	es
	er de	Funerai	11. Marital Status	12. Was Deceder Armed Forces	?	S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic On oan, Mexicar	igin? (Spe n, Puerto l	cify Yes or No Rican, etc.)	- 14.	Race - Americ Black, White,	
36	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than *natural; or items 23s or 28s-f show atic event, the Medical Exam are must be rediffed at	by F	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates			1 □ Yes 2 🔀 No	Specify:	:		Sp	ecify: Whi	te
Maryland 21215-0036	2 hou	ted	15. Decedent	's Education		16a. Dece	dent's Usual Occur	pation			16b Kind	of Business/Inc	
215	Pin 7	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4o)	(5+)	(Give life.	kind of work done DO NOT use retire	during mos	st of workin	ng	rob. King	01 243111033/111	dustry
7	od wil	Con	8th	<u> </u>		Tı	ruck Driv	er			Cit	y Expre	ess
p	be file tal Hy d oth	Be (17. Father's Name (First, Middle, L	,						(First, Middle,		mame)	
<u>X</u>	should ind Men s marks umatic	ပ	Marshall G. Ca							Frizze			
Mai	12 sh h and 7 ie n traun	Ш	19a. Informant's Name/Relationsh Eva Carr Wife				ng Address (Street						
	ges 1 and 2 should be filed within 72 hours after death with the Marylan t of Health and Mental Hygiene. If item 27 ie marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinational barrafilled at		20a. Method of Disposition		20b. PI		Frock Dr	ive		203 W			
ğ			1 ☑ Burial 2 ☐ Cremation		a C6	emetery, cren	natory or other pla	,				on - City or To	
altimore,	permit. Page Department of Important: if eny injury or once.	- 1	* 4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service L		LIII	22	re Cemete	ess of Facilit	tv				Maryland
m	Per Per Per Per Per Per Per Per Per Per		Allman 18	(aum		Bυ	rrier-Qu 212 W. Ol	een F	unera	al Dire	ctors	P.A.	21784
			23a Part . Enter the disease, or of shock, or heart failure. List of	complications that cause	d the death	. Do not ent	er the mode of dyir	ng, such as	cardiac or	respiratory ar	WITTIE rest,	era, MD	Approximate
J	Enysician		Immediate Cause (Final		14								Interval Between Onset and Death
	/Medical		dis ase or condition rulting in death)	a. Due to (or a	s à consequ	ence of):				-		- 0	Live
	Examiner		Sequentially list conditions	145	CVI	\sim							2540
	ed sit	line	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	Due to (or a	s a consequ	ence of):	1						
	and and Il-tran	Examiner	that initiated events resulting in death) Last	c Due to (or a	s a consequ	ence of):	-					C	144
8760	certificate be executed Iding physicien and Ise as the burial-transit	dicai E										ı II.	J
89		edic		0.								- 1	
Rox	eath certific attending p	hysician/Me	JF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnan		Imakania ana				23d.	Date of deliver	ry
	ed for u	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a			Ectopic pregnancy Other (specify)	/				Month I	Day Year
	at the de d by the etached	Phy	9 Unknown										
Ś	as the	ρ	Part II. Other significant condition	is contributing to death	but not resul	lting in the ur	iderlying cause giv	en in Part I.					a cause of death?
Š	w require been signal	etec								1 🗆 Yı	es 2 de Mi	3 Proba	ably 4 Unknown
Hecord	The lav ate has page 2:	ompleted								24a. Was a autops perform	SV .	 b. Were autop prior to com death? 	sy findings available apletion of cause of
		ပို .	25. Was case referred to medical							1 ☐ Yes	2□No	1 Yes	2 No
5		0 0	examiner?	Hospital:	ent 2 🗆 E	R/Outpatient	3□ DOA Othe			<i>Check only on</i> e 5 ☐ Reside		24	-
	D 0 0	_	27. Manner of Death	28a. Date of Inj	ury 2	28b. Time of	28c. Injun Worl			Bd. Describe ho			
Ö	Attending F r death. sctor: After by the funer	atio	1 ☐ Natural 5 ☐ Pending investiga	ation	iy 16a1)	Injury		k≀ Yes 2 □ N	No				
DIVISION	r Att	ertificatio	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and 286. Place of in	jury - At hon tc. (Specify)	ne, farm, stre	et, factory, office		28	If. Location (St. City or Town	reet and Nu	mber or Rural	Route Number,
ם	oitel o urs af rel Di	O									,		
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	29a. Certifier 1 ☐ Certifying (Check only one) 1 ☐ Certifying 2 ☐ Medical E	Physicien: To the best xeminer: On the basis of	of examination	rledge, death on and/or inv	occurred at the time estigation, in my or	ne, date and pinion, deat	d place, an	d due to the ca	ause(s) and ate and plac	manner as sta	ted.
	o the ithin 2 o the omple		29b. Signature and title of certifier	and manner st	ated.		29c. License					r∮ed (Month, D	
1	F 3 F 8		1/2 /2	Dr. 101	1		7)2	CVV	2		Ju. Dato sig	1	ay, rear)
	HW		30. Name and address of person w	no completed cause of	death (Item 1	23a) (Tyne F	Print)	7 1 [)_		1	4/2	004
	5		(I Tohn h	midde	letin	68	8Pal	R	16	Varta	1.m :7	E M	1 21157
K. P	Stat		31. Data filed (Month, Day, Year)	32. Regist	ar's Signatu	ire			1		x-610 F	7	1 24/2/
	Registra	ir	MAY 2	4 2004 200	ene	# 6	berte						

			For 1 - State Registrar	State o	f Marylar		artmen ertificat				fental Hy	giene Reg. Ne	0.07	11.	10001
	Physici /Medic		Decedent's Name (First, Middle, Lillie Mae CRO)								2. Date of De Month May 2	Da	2004 Y	ear /	3. Time of Death
	Examin		4a. Facility Name (If not institution, g Eden Pines Ass:	isted Liv	ving		Н	ager	Stown	1				shing	
	uneral irector		5. Social Security Number 258-72-9428 Usuel Residence of Decedent	.Sex 1□M 2⊠F	7. Age (In yrs. 98	last birthday Yrs.	Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da Nov. 19	th ly, Year 1,190	05		ce (State or Foreign () LESSEE
Maryland	a-f ehow	ctor	10a. State 10b. County	ngton		y, Town or L Hagers								10d.	I. Inside City Limits 1 ☐ Yes 2 ☒ No
th with th	23a or 26 ist be no	al Director	10e. Street and Number 11423 Longview	Drive			10f. Zip		740				tizen of Wha SA	it Country	n
III C (C 13-0030 be filed within 72 hours efter deeth with the Maryland	al', or items : Examiner mu	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Fo	2.23.No ∕e	.S. 13.	Was Deced If Yes, spec		ispanic Ori in, Mexican Specify:		ecify Yes or No Rican, etc.)	-	14. Race Black, \ Specify:	American White, etc Whi).
In 72 ho	n "natur Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		I-40r 5+\	(Give	edent's Usua e kind of woi DO NOT us	rk done d	during mos	t of work	ing	16b. K	(ind of Busin	ess/Indus	itry
Id be filed with	Important: if Item 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Madical Examiner must be notified at once.	To Be Com	12 17. Father's Name (First, Middle, La Alfred Fryer	4			scho	ol t		er's Name	e (First, Middle,	Maider		scho	ool system
and 2 should	n 27 is mar er traumati	_	19a. Informant's Name/Relationship John Boring - gi			114	23 Lo	ngvi		., H	al Route Number				
t. Peges 1 at ment of He	rant: if Iten Jury or oth		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe	cify)	State	Place of Disp cometery, cre odlawi	n Memo	ria]	l Parl	k 5	/26/04	Nas		e,Te	nnessee
permit.	eny lr		21. Signature of Euneral Service Lic	t M/	Tuns	1 12	2. Name an 415 E.				MINNICH , Hager				
/M	sician edical iminer		23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	ly one cause on e	nused the deat ach line. (or as a donsed	rera!	ter the mod	e of dying	g, such as	cardiac d	or respiratory and	rest,	2	in	pproximate iterval Between nset and Death
be executed	physicien end s the buriel-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	or as a conseq							_			
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quires thet	an signed by	۵	Part II. Other significant conditions	contributing to de	eath but not res	ulting in the u	inderlying ca	ause give	en in Part I.			obacco i res 2			cause of death? y 4 ∐Unknown
The law re	cete hes ber , pege 2 sho	Completed									1 ☐ Yes	rmed?	prior	to comple	r findings available letion of cause of No
/siclar	s certif directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	npatient 2	ER/Outpatie	nt 3 DO	A Othe			n <i>(Check only o</i> me 5 ☐ Resid		6 □Other /5	Specify)	
ndlng Ph	To the Funeral Director: Atler this certificate hes completely filled in by the funeral director, pege 2:	atlon; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date (Monition	of Injury th, Day Year)	28b. Time of Injury		Bc. Injury Work			28d. Describe h			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
tal or Atte	sl Directo ed in by th	Certification;	3 Suicide 6 Could not determine	289. Place	of Injury - At hong, etc. (Specif	ome, farm, st	reet, factory	, office		1	28f. Locetion (S City or Tow			r Rural Ro	oute Number,
ihe Hospi in 24 hou	the Funer	Medical	(Check only 2 Medical Ex	Physicien: To the eminer: On the ba and man	best of my kno asis of examina ner stated.	wledge, deat tion and/or in	vestigation,	in my op	inion, deat	d place, a	ed at the time, o	date and	d place, and	due to the	e cause(s)
ToT	0 00 1	2	29b. Signature and title of certifier	11/	(n	Mn	290	License	362	3		29d. Dai	te signed (M	onth, Day	Zuvy
JH'	9		30. Name and address of person where	- Kar	STIV	MA	Print)	W	me	de	cel Co	2	pu)	Ĉe	λ
	Sta	te	31. Date filed (Month Day) (Year)	200 A 32. R	gistrar's Signa	ture	1 1					. 1	-		

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of N	Maryland / Do	epartment Certificate				giene Reg. No 20 (18235
	Physici /Medio			Lee CASH					2. Date of De Month	all ac	Year 0345 A M
	Examir	ier	4a. Facility Name (If not institution, gi	y Hospita	1	Hag	own, or Locat	n			nington
	Funeral Director		5. Social Security Number 215–18–2536 Usuel Residence of Decedent	Sex 7. A 1 □ M 2 ☑ F	Age (In yrs. last birth 82 Yr	Monthe	Days Hou	der 24 Hr rs Mir	. (Month, Da	th 19, Year) 3, 1922	9. Birthplace (State or Foreign Country) Virginia
	ter death with the Maryland thems 23a or 28a-f show the nutified at	ctor	10a. State 10b. County Maryland Washing	ton	10c. City, Town						10d. Inside City Limits 1 Yos 2 □ No
	th with the 23a or 28 Int by no	al Directo	10e. Street and Number 307 East Wilson	Blvd.		10f. Zip C	217	40		10g. Citizen of W	hat Country?
9000	72 hours after death with the Maryland Insturel' or items 23s or 28s-f show dical Examber must be invilled at	d by Funeral	11. Marital Status 1. ■Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates]No	13. Was Decede If Yes, specif			Specify Yes or No rto Rican, etc.)		- American Indian, , White, etc. white
Maryland 21215-0036	d within 72 piene. r than "nai	Completed	15. Decedent's E (Specify only highest g. Elementary/Secondary (0-12) 0-12			ecedent's Usual Give kind of work ife. DO NOT use bookkee	done during retired)	most of w	orking	16b. Kind of Bus	
/land	2 should be filed and Mental Hygin is marked othar aumatic evant, II.	To Be C	17. Father's Name (First, Middle, Las Paul Edgar C	•			18. M	other's Na		Maiden Sumame L Lee Mor)
	T te		19a. Informant's Name/Relationship Charlotte Stucke		r 239	92 Landi	s Lane			er, City or Town, S 28761	itate, Zip Code)
Baltimore,	of H fital		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 (4 ☐ Donation 5 ☐ Other (Spec	ify)	e cemetery,	isposition (Name crematory or oth ill Ceme	er place)		ay ₀₀₄ ,	Hagersto	own, Maryland
Ball	permit. Pag Department Ir portant: t any injury o		21. Signature of Funeral Service Lice	l'			t Wils	on B	Lvd., Haş		IOME Maryland 21740
	Physician /Medical		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. PNE	/ M (M) #	1			ac or respiratory a	rrest,	Approximate Interval Between Cheet and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. ASTH	MATIC	131501	VCUT	775	745 -		YEARS
8760,	cate be executed bhysician and the burial-transit	dicai Examine	Cause (Disease or Injury that initiated events resulting in death) Last		BZAL U s a consequence of) ERTEN		m)12 E	73) E		YEARS
.O. Box 6	death certifi e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 Fetal death at time of death	3 □Ectopic preg 5 □ Other (spec				23d. Date Mont	
σ.	w requires that the been signed by the should be detache	by	Part II. Other significant conditions	contributing to death	but not resulting in the	ne underlying cau	ise given in P	art I.		./	oute to the cause of death?
Vital Records	The law ate has b page 2 s	Completed				1			24a. Was autop perio 1 Yes	rmed? pri	ere autopsy findings available or to completion of cause of ath? Yes 2 \(\text{No} \)
Division of Vit	ding Phys h. After this funeral di	ation: To Be	25. Was case referred medical examiner? 1 Yes 2 No 27. Manner Death 1 Autural 5 Pending investigation	Hospital: 1 Inpar 28a. Date of In (Month, D			Other	Nursing		ne dence 6 □Other now injury occurred	
Divis	sal or Attanus after death	Certification:	3 Suicide 6 Could not determined	28e. Place of I	njury - At home, farm etc. <i>(Specify)</i>	, street, factory, o	office		28f. Location (S City or Tov		or Rural Route Number,
	To the Hospital or Attan within 24 hours after deatl To tha Funaral Diractor: completely filled in by the	edical	one) 2 A Medical Exa	hysician: To the bes miner: On the basis and manner s	of examination and/o	or investigation, in	n my opinion,	death occ	e, and due to the urred at the time,	cause(s) and manr date and place, an	ner as stated. d due to the cause(s)
)	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	æ	29b. Signature and title of certifier	ghi /	JUOSIL	29c. l	JOZ Z		_	29d. Date signed ((Month, Day, Year)
	JH ~		30. Name and address of person who	(A) CA	death (Item 23a) (Ty	Print)			DWN	MD.	21742
	Sta Registr		31. Date filed (Month, Day, Year)	2004 32. egis	trar's signature	Sperker	1				

			State of Maryland / Department of Health 1 - State Registrar Certificate of Deatl		Reg. N	/	18236
	Physicia	an	1. Decedent's Name (First, Middle, Last)	N.	Date of Death	Dav Year	3. Time of Death
	/Medic Examin	al	MAUDE ELIZABETH DIXON 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location		AY 25	2004 4c. County of Death	6:00 AM ^M
	Examili	ei	14901 Candy Hill Road Upper Marlb			Prince Geo	
	Funeral Director		212 62 0502	s Min. (A	ete of Birth Month, Day, Yea Ct 10,		place (State or Foreign ntry) yland
	ס		Usual Residence of Decedent				
	Maryla f shov	ŏ	Maryland Prince George's Upper Marlboro				10d. Inside City Limits 1 ☐ Yes 2 No
	th the	Director	10e. Street and Number 10f. Zip Code		10g. (Citizen of What Cour	ntry?
	s 23a	erai 🗆	14901 Candy Hill Road 20772 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Company in U.S.	Origin? (Specify)	Vac or No	USA 14. Race - Americ	can Indian
036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It health and Mental Hygiene. Item 27 is marked other than "naturel", or flems 23a or 28e-f show other traumatic event, the Madical Examinational Leading of the fraumatic event.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ★ No If Yes, specify Cuban, Mexic If Yes, Give Year or Dates:		n, etc.)	Black, White, Specify: Whi	etc.
15-0	n 72 ha "natu	letec	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during modified DO NOT use retired) If DO NOT use retired)	ost of working	16b.	Kind of Business/In	dustry
21215-0036	e filed within at Hygiene. I other than "	Completed by	Elementary/Secondary (0-12) College (1-4or 5+) Housewife		Ov	wn Home	
	be filed ital Hygir d other event, II	Be		ther's Name (Firs			
Maryland	2 should be and Mental Is marked c	ဥ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num				Code)
	1 and 2 Health a tem 27 Is		Ida M. Armiger (Daughter) 14811 Candy Hill				
Baltimore,	ages 1 nt of He : If iten or oth		20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) 20cemetary, crematory or other place) 20cemetary, crematory or other place) 20cemetary, crematory or other place)	Date 5-29-04		Location - City or To	
atin	permit. Pages 'Department of H Important: If ite any Injury or of		*4 Donalion 5 Other (Specify) Methodist Church 21. Sign of Fuve al Service Licensee M00173 **Rethodist Church** 22. Name and Address of Factors*	-104		per Marlbo neral Serv	
ä	Departing Departing Important any Ir		Win A Cheur 4433 White Pls	. La. Wh	nite Pla		
			23a. PANT Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a block, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Physician		disease or condition resulting in death)	10/12	Vξ		9/4/4
	/Medical	l I	Due to (or as a consequence or):			11	
Į	/Medical Examiner	<u>.</u> .	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of):	Causic	VAJU	(AL DIKAR	year
	Examiner	miner	rf any, leading to immediate Due to (or as a consequence or): cause. Enter Undertying Cause (Disease or injury	Causic	UM COM	(AL DIKAD	year
90,	Examiner	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	Causic	VAJUN	(Ar Dikas	year
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)	/Medic Examin	al	4a. Facility Name (If not institution,		JONE L			Location of		AY 14	_	004 County of Deat	8:43	Α
	Examin	er	4888 ARTERS M	*		WE	STMI	NSTE				CARROL		
	Funeral Director		216-40-9267	5. Sex 7. Age (I 1 M 24€ F 6	In yrs. last birth	Months	Days	If Under 2 Hours	Min. 8.	Date of Birt (Month, Day AY 20	h y, Year) , 19	9. Birth Co 42 WES!	nplace (State o untry) L VIRG	
	land		Usual Residence of Decedent 10a. State 10b. County	11	0c. City, Town	or Location				-			10d. Inside Ci	ty Limits
	ath with the Marylar 23a or 28a-f show	tor	MD. CARRO	LL	WESTM	INSTE	R						1 🗌 Yes	2 [XNo
	or 28	Director	10e. Street and Number			10f. Z	ip Code					zen of What Co	untry?	
	s 23a	erai	4888 ARTERS 11. Marital Status	MILL RD.	er in U.S.	13 Was Dec		158	nin? (Specify	v Yes or No		JSA 4. Race - Ame	ncan Indian.	
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215-0036	72 hours 'natural', dical Exa		15. Decedent's (Specify only highest	Education	16a. C	ecedent's Us Give kind of w	ual Occupa	ation during most	of working		16b. Kir	nd of Business/	Industry	
2	be filed within 72 hc tal Hygiene. d other than "natur event, the Medical	Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ife. DO NOT BOOKK	us <i>e retire</i> a)			СІТУ	GOVE	RNMENT	
2	fited v Hygie other t	င္ပ	12 17. Father's Name (First, Middle, L.	ast)					r's Name (F	irst, Middle,	Maiden	Sumame)		
/lan	should be nd Mental nmarked o	To B	RAL	PH HERMAN I	BALLEN	GEE		MAT	TIE I	LORRA	INE	BENNE	TT	
Maryland	2 4 2 8		19a. Informant's Name/Relationshi	p (Type, Print) GROSS-DAUGI								Town, State, 2		15
altimore,	Pages 1 and 3 nent of Health int: If Item 27 iry or other tr		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp.	3 □Removal from State	20b. Place of I cemetery ST. MA	Disposition (Na crematory or RY S	other plac	_{e)} 5	/18 / 0			cation - City or VER RU		
Balti	permit. Pages Department of Important: If it any injury or once.		21. signature Service L	censee								NERAL : ER, MD		57
Sales of the sales	Physician //Medical Examiner e particular literations of	Examiner	23a. Part1. Enter the disease, or of shock, or hear failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a c	consequence of	Partas	eas	+ 0	C13			vec	Approximation and Interval Bet Onset and Interval Methods and Interval M	e ween Death Court Ly
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.O. Box 68	that the death certificate be ex ed by the attending physician detached for use as the burial	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 I 4 □ Pregnant at tin 9 □ Unknown	Fetal death	3 ☐Ectopic 5 ☐ Other (s					2	3d. Date of del	*	Year
٥.	s that t ned by s detac	y Ph	Part II. Other significant condition	s contributing to death but	not resulting in	the underlying	cause giv	en in Part I.		23e. Did to	obacco u	se contribute lo	the cause of d	leath?
rds	w requires to been signed should be									101	res 2	ZNo 3□Pr	obably 4 🔲	Jnknown
Records,	The law re ate has be bage 2 sho	Completed										24b. Were au prior to death?	topsy findings completion of c	available ause of
<u>ita</u>	cian: ertifica ector, j	Bec	25. Was case referred to medical examiner?	I de accidente				_		Check only o				
Division of Vital	Attending Physician: The law requires that the redain. releath. sctor: After this certificate has been signed by the tuneral director, page 2 should be detach.	ion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investig				28c. Injur Wor		28d	5 🕅 Resid 1. Describe t		Other (Spec	cify)	
Division		Certification:	2 Accident investig: 3 Suicide 6 Could not determine	ot be Ricco of Injury	r - At home, fari (Specify)	m, street, facto				Location (S City or Tox		d Number or Ru	ral Route Num	ber,
_	the Hospital or hin 24 hours after the Funaral Dir npletely filled in	edical C	29a. Certifier 1 Certifying (Check only 2 Medical E	g Physician: To the best of examinar: On the basis of examinar and manner state	xamination and	death occurre	d at the tin	ne, date and pinion, deal	d place, and Ih occurred	due to the at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s	.)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1/	1///	2	9c. Licens	e number			29d. Date	e signed (Monti	n, Day, Year)	. 4.1
•	WJL		• / ~	1/1	X		1035	1au	2		Na	417	n 2ct	14
	5		30. Name and address of persons	Bootasch	endiku		Sur	er A	tue 1	west	min	ten W	0,2	1157
h	Sta Registi		31. Date filed (Month, Day, Year) MAY 1	32. Registrar's		Loc	د نک							

DHMH 17 Rev 1/2001

Registrar DHMH 17 Rev 1/2001

State

7 2004

State of Maryland / Department of Health and Mental Hygiene For Stata Registra Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** MAY 25, 8:40 AM 2004 LIIVADA RUTH FOLEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Oeath Examiner GARRETT DENNETT ROAD MANOR NURSING HOME OAKLAND If Under 1 Year If Under 24 Hrs.

Months Oays Hours Min. 8. Date of Birth (Month, Day, Year) AUG 7, 1912 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Months MARYLAND **Funeral** 1 □ M 2 🕅 F 91 235-44-4838 Director Usual Residence of Oecedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County or Items 23a or 28e-f show the Medical Examiner must be notified at 1 Yes 2 □ No GARRETT OAKLAND Director MD 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number USA 21550 201 E. MASON STREET Be Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Oecedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. ☐Yes 2X No f Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yas 2 X No Specify: Specify: WHITE 3 X Widowed 4 ☐ Divorced Year or Dates: 'natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Importent: If item 27 Is marked other tt any injury or other traumatic event, IIIa once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CLARA STEYER SHOCKEY BENJAMIN 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) McHENRY, MD 21541 6894 SANG RUN ROAD LARRY W. FOLEY - SON Date 20c. Location - City or Town, Stata 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5/28/04 OAKLAND, MARYLAND WHITE CHURCH CEM. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signatur # Funeral Service Li P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550 oller M00167 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death Immediate Cause (Final 7 years Physician Consestive Heart Failure disease or condition rasulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day ŏ 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Inpatient this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred filled in by the funeral 27. Manger of Death Certification: After or Attending 1. Natural 5 Pending М 1 Yes 2 No death. investigation 2 Accident after death Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide within 24 hours a
To the Funeral I
completely filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie runn 05/25/2004 D27205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oakland, MD 311 N Fourth Street Karl E. Schwalm, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 200# Registra

Amended Item 26 per Physician 05/19/2004 Carroll County, wjl
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

V.	Physic		1 - State Registrar 1. Decedent's Name (First, Mid Linda Ann F	dle, Last)	State of M	Maryland	•			ealth and Death	Mental H	Reg. No.		3. Time of Dea
>	/Medi Exami		4a. Facility Name (If not institute 1319 Stone Ro	on, give str	eet and numbe	ər)		-		Location of Dea	-		County of Death	
(6)	Funeral Director		5. Social Security Number 220–38–6532 Usual Residence of Decedent	6. Sex 1 ☐ N	7. / 4 252 F	Age (In yrs. Ia		If Under Months	1 Year Days	If Under 24 Hrs Hours Min	8. Date of E (Month, I Sept	oay, Year) 25 19	9. Birth Con	place (State or For intry) MD
	Maryland f show	tor	10a. State 10b. Coun	arrol	1		, Town or La		r					10d. Inside City Lin
	th with the 23s or 28s	Funeral Director	10e. Street and Number 1319 Stone R					10f. Zip	Code	158		10g. Citiz	zen of What Co	intry?
980	i within 72 hours after death with the Maryland liene. Then "natural", or Items 23a or 28a-f show the Mudicul Evants at coultied at	þ	11. Marital Status 1 Never Married 2 A Marital 3 Widowed 4 Divorce	arried	. Was Deceder Armed Force 1 Yes If Yes, Give Year or Date:	s?]No		Was Dece f Yes, spe 1 ☐ Yes	cify Cuba	spanic Origin? (: n, Mexican, Pue Specify:	Specify Yes or to Rican, etc.)		14. Race - Amer Bleck, White Specify: Wh	, etc.
21215-0036	within ane. then	Completed	15. Decedi (Specify only high Elementary/Secondary (0-12	-		or 5+)	life.	tent's Usu kind of wo DO NOT u	rk done d se retired	furing most of wo	orking		nd of Business/l	ndustry
Maryland ?	be filed ital Hyg od othe event,	To Be C	17. Father's Name (First, Middle John Downey	e, Last)							me (First, Midd F is hpaw	le, Maiden		
	is 1 and 2 ships the stranger of the stranger traum.		19a. Informant's Name/Relatio Tim Faber/husl 20a. Method of Disposition 128 Burial 2 Cremation	oand		te C6	1319 ace of Dispo	Sto sition (Nai natory or c	ne R	9) 5/2	iura <i>l Route Nurr</i> stminste 192004	r, MD 20c. Loc	21158 cation - City or 1	own, Stete
Baltimore,	permit. Page Department of Important: If eny Injury or once.		* 4 □ Donation 5 □ Other 21. Signature of Funeral Service			Me	22	Priee	g Aggre	netery herally ngton Ro	ome and	Chape	stminst 1, P.A.	
3 .	Physician /Medical Examiner		23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	or complica st only one	Mul-	sed the death line. The Manager	Seles	er the mad	le of dyin				ter Mi)	21157 Approximate Interval Between Onset and Death
oo,	n \$	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitted events resulting in death) Last	b		as a consequ								
O. BOX 00/00,	death certificate e attending physod for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2⊿₹€0 9 ☐ Unknown	d		2 ☐ Fetal at time of de	death 3[Ectopic pi Other (sp				2	3d. Date of delik	ery Day Year
S, T	es lha	by	Part II. Other significant condi	tions contri	ibuting to death	n but not resu	iting in the u	nderlying o	ause give	en in Part I.			_	the cause of death
Hecord	The law ate has b page 2 si	Completed									24a. Wa aut per 1 🗆 Yes	opsy formed?	24b. Were aut prior to co death?	opsy findings available ompletion of cause
r Vital	ystcian: is certific director.	To Be (25. Was case referred to media examiner? 1 Yes 2 No		spital: 1 🗌 Inpa	atient	Frompuno	- 3□ DC	Othe	AC.	ath (Check only	one)	Other (Speci	fy)
	ding After fune	ertification:		ling stigation	28a. Date of It (Month, I	njury Day Year)	28b. Time of Injury	M	8c. Injun Worl	at ∴? res 2 □ No	28d. Describe	how injury	occurred	
Division	I or Atten after deatl Director:	ertific	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	d not be mined	28e. Place of building,	Injury - At horetc. (Specify	me, farm, str	eet, factory	r, affice		28f. Location City or T	(Street and own, State)	Number or Rur	al Route Number,

To the Hospital or Attanding Physicial within 24 hours after death.

To the Funeral Director: After this certif completely filled in by the funeral directo

Medical Certification: To

6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier

Description of the state of death (Item 23a) (Type, Print)

Stephen J. S. Kons M., MrD. 912 Washington Rd Westminsterm)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

Physicia /Medic	212	1. Decedent's Name (First, Middle,					2. Date of D Month	Day	/ Year	3. Time of Dea
		Lucille	Goldie	Gra	aham		May	29,	2004	4 8:20p
Examin		4a. Facility Name (If not institution,		4b. 0	•	Location of Dea	th	4c.	County of De	
		Beverly Health		et hirthday) If I	red	erick	R Date of B	irth	Freder	
uneral irector		5. S Q1 1 2 00 4 N 6 5 4 5 225-28-6515 Usual Residence of Decedent	6. Sex 7. Age (In yrs. la 1	Mon		Hours Min		аў Year) , 19	12 V	irthplace (State or For Country) irginia
fied at	tor	10a. State 10b. County Maryland Frede		, Town or Location Freder						10d. Inside City Lin
3e or 28e st be not	Funeral Director	10e. Street and Number 30 North Place		10f	Zip Code 217	701		-	U.S.A.	Country?
administry of them 27 is marked other then "naturel", or flems 23e or 28e-f show orient it flem 27 is marked other then "naturel", or liters as the notified at injury or other treumetic event, the Modical Examination assistant as 18.8.		11. Marital Status 1 Never Married 2 Marrie 3 X Vidowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1		ecedent of H specify Cuba es 2 💢 No	ispanic Origin? (in, Mexican, Pue Specify:	Specify Yes or N nto Rican, etc.)	0-	Black, Wh	nerican Indian, nite, etc. White
then "natur re Medical I	Be Completed by	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed) College (1-4or 5+)	16a. Decedent's (Give kind o life. DO NO Homema	if work done o DT use retired	ation during most of wo	orking	16b. K	of Busines Own H	
arked other then etic event, Ir e M	To Be Co	17. Father's Name (First, Middle, L John	William	Mar	nn	18. Mother's Na	me (First, Middl Sele:		Sumame) Hou	ıgh
is mai		19a. Informant's Name/Relationsh	nip (Type, Print)	19b. Mailing Add						
item 27 i		Mrs. Audrey Re	20b. Pla	ace of Disposition	(Name of		Frede		Mary 1	and 21703 or Town, State
ant: If if ury or o		1XXBurial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (Sp	3 Hemoval from State	on Cemete on Cemete	ery	Jun 3,				le, Virgin
Importent: If its eny injury or o		21. Signature of Funeral Service to	Be MOOT	706 106	e and Address ley & l East (ss of Facility Basford Church S	P.A. Fu	neral erick	Home Mary	land 21701
ysician		Immediate Cause (Final	complications that caused the death. only one cause on each line. End Stage	. Do not enter the	mode of dyin	g, such as cardia	c or respiratory	arrest,		Approximate Interval Betweer Onset and Deatl Years
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DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and N 1- State		giene200	4 18242
			1. Decedent's Name (First, Middle, Last)	2. Date of De	ath	3. Time of Death
	Physici		Donald H. Hardesty	May	Day Year (9 200	
	/Medio Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	11.1000	4c. County of D	
	Exami	iei	Sinai Hospital of Baltimore Baltimore		None	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Bir (Month, Da		Birthplace (State or Foreign Country)
	Director		212-20-3504 12 M 2 F 80 Yrs. Months Days Hours Min.	June 23	, 1923 Ma	ryland
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	-		10d. Inside City Limits
	aryla shov	Ľ				1 ☐ Yes 2 🖾 No
	Sa-1	Director	Maryland Howard Mount Airy 10e. Street and Number 10f. Zip Code		10g. Citizen of What	Country?
	with the Maryland a or 28a-f show Lb- notified at					,
1	eath	Funeral	701 Middletrail Court 21771 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No	United S	merican Indian,
7	ter d Item	'n.	Armed Forces? If Yes, specify Cuban, Mexican, Puerto 1 □ Never Married 2 ★ Married 1 ★ Yes 2 □ No	Rican, etc.)	Black, W	hite, etc.
0	036 / ours after death w rai', or items 23a Executive cust 1	by	If Yes, Give 1 ☐ Yes 2⊠ No Specify: Year or Dates: WWII		Specify: V	√hite
Hardes		Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	rina	16b. Kind of Busine	ss/Industry
5,	21.2 B	ple	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired) (Give kind of work done during most of work life. DO NOT use retired)	arig		
T	21 Major th	Con	2 Engineer		Manufact	uring
7	Ind 21215-0036 be filed within 72 hours after death tal Hygiene. d other than "natural; or items 23 svent, the Moucal Examiner rust	Be			, Maiden Surname)	
to la	aryla should to ind Ment in market umatic	2		ret Die		
onald	Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. 27 Is marked other than "natural", or traumatic svent, the Modeul Exeru		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run			
0	re, Maryland 21215-0 s 1 and 2 should be filed within 72 hc Health and Mental Hygiene, ttem 27 le marked other than "natu		Jane Hardesty / Wife 701 Middletrail Court 20a. Method of Disposition (Name of	Mount Date	Airy, Mary 20c. Location - City	
	ges it of h		Zoa. Welfied of Disposition	7 22.		
`	altimore, mit. Pages 1 ar partment of Hea portant: If item y injury or othe		'4 □ Donation 5 □ Other (Specify) Crest Lawn Mem. Gardens 21. Signature of Fineret Service Licensee 22. Name and Address of Facility C. 1.	2004	Marriotsv	ille, Maryland
	Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene, Important: If item 271 is marked other than any injury or other traumatic event, ILE M.		6 E. Ridgeville Blvd	d. Mt.	Airy, Mar	es, P.A. yland 21771
			23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory a	rrest,	Approximate Interval Between
	Physician	ı	Immediate Cause (Final disease or condition Meta Static Bladle Cancer			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
	Examine	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	ed sit	ine	rany, leading to immediate Due to (or as a consequence or). Cause (Disease or injury that initiated events c.			
	8760, cate be executed brysician and the burial-transi	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
	8760, cate be ex physician a					
		edical	U.		P	
		N/W	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of	delivery
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	by the	hys	9 Unknown	_		
	of Vital Records, P.O. Box 6 Physician: The law requires that the death certificate has been signed by the attending I rathic certificate has been signed by the attending I rathic director, page 2 should be detached for use as	by Physician/M	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Per : [Prod VASC On d =]			e to the cause of death?
	Cords w require been sig	led		1 🗹	Yes 2 No 3	Probably 4 Unknown
	Reco	Completed	CArdine disease	24a. Was	an 24b. Were	autopsy findings available to completion of cause of 1?
	The The page	NO.		perfo 1 ☐ Yes	ormed2 death	i? ′es 2□ No
	Vital Fidician: The certificate	Be (25. Was case referred o medical examiner?			
	ohyeid Phyeid this c	ြို	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho			pecify)
	Jing P	on:	27. Manny of Death 1 1 stural 5 Pending investigation investigation	28d. Describe	how injury occurred	
	Vision Attending r death. ector: After	icat	3 Suicide 6 Could not be	28f Location /	Street and Number or	Rural Route Number
	Division of Vital Records, P.O. Box to Attending Physician: The law requires that the death cer after death. Director: After this certificate has been signed by the att indin by the funeral director, page 2 should be detached for use	Certification;	4 Homicide determined building, etc. (Specify)	City or To		, total riodic riombor,
	spital cours neral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the	cause(s) and manner	as stated.
	Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated. 29b Signature and title of certifier 29c. License number	rred at the time,	date and place, and of	
	To To		29b. Signature and title of certifier 29c. License number 29c. Lic		05-10	1-2004
	wtl		30. Name and address of person who completed cause of Beath (Item 23a) (Type, Print) 2401 W. Pelukkul AVL BAH:	roda	117 3	112/5
	St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature 4 2004			
		1.0				

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2 \left(\right) \left(\right) \left[\right]$ Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Violet Duvall Handley /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Carroll Hospital Center Westminster **Funeral** HANDLEY Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland or 28a-f show injury or other traumatic event, the Madical Examiner must be notified at To Be Completed by Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s canny injury or other traumatic event, the Medical Exerciper mast a suce. Baltimore, Maryland 21215-0036

18244

2035

2. Date of Death 3. Time of Death

2004

Carroll

4c. County of Death

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2115

29d. Date signed (Month, Day, Year)

2005

14 Day

Month May

S Social Security Number 215-26-1053 10	5. Social Security No	ımber	6. Sex		7. Age (In	rs. last birt	hday)	If Under		If Und Hour	ler 24 Hr s Mir	8.	Date of B	irth	,	9. Birth	nplace (State	or Foreign
100. County 100. County 100. City, Town or Location 101. 20 Code 102. Strong and Number 102. Strong and Numbe	215-26-10	053	1 M	2 X F		74	Yrs.	Months	Days	riour	3 14111	. 5	Sept	13	1929		M	D
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Month Carrol Westmunster 10/2 p Code 10/2 Citizen of What Country? 10/2 S Stone Road 12 Was December Series in U.S. 13 Was December of Hispanic Origin? (Specify Yes on No-12 Was December of Hispanic Origin? (Specify Yes on No-12 Was December of Hispanic Origin? (Specify Yes on No-12 Was December of Hispanic Origin? (Specify Yes on No-12 Was December of Hispanic Origin? (Specify Yes on No-12 Was December of Hispanic Origin? (Specify Yes on No-12 Was 28 No Specify: White Specify: Wh	10a. State	10b. County	′		10c	City, Town	or Loc	ation										
11. Marial Status 12. Marial Status 13. Marial Status 14. Marial Status 15. Decadent's Usual Observation, mon. Marial Status 15. Decadent's Usual Observation, mon. Marial Status 15. Decadent's Usual Observation, mon. Marial Status 16. Decadent's Usual Observation, mon. Marial Status 17. Father's Name (First, Middle, Marialen Surmanne) 17. Father's Name (First, Middle, Marialen Surmanne) 17. Father's Name (First, Middle, Marialen Surmanne) 17. Father's Name (First, Middle, Marialen Surmanne) 18. Burial 2. Ceremation 3 Removal from Status 18. Burial 2. Ceremation 3 Removal from Status 18. Burial 2. Ceremation 3 Removal from Status 18. Burial 2. Ceremation 3 Removal from Status 18. Burial 2. Ceremation 3 Removal from Status 18. Burial 2. Ceremation 3 Removal from Status 19. Part 1. Enter the disease, or complications that caused the deem. Do not enter the mode of ying, such as cardiac or respiratory arrest. 19. Due to (or as a consequence of): 19. Due to (or as a consequence of): 19. Due to (or as a consequence of): 19. Due to (or as a consequence of): 19. Due to (or as a consequence of): 19. Due to (or as a consequence of): 19. Due to (or as a consequence of): 19. Due to (or as a consequence of): 19. Due to (or as a consequence of): 19. Due to (or as a consequence of): 19. Due to (or as a consequence of): 19. Due to (or as a consequence of): 19. Due to (or as a consequence of): 19. Due to (or as a consequence of): 19. Due to (or as a consequence of): 19. Due to (or as a consequence of): 19. Due to (or as a consequence of): 1			roll_			Wes	tmi							1				2 2 400
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15. Decedent's Lisual Occupation (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give And divork done during most of working its Book Name (First, Middle, Last) 17. Father's Name (First, Middle, Last) 18. Molher's Name (First, Middle, Last) 19. Molher's Name (First, Middle, Last) 19. Molher's Name (First, Middle, Last) 19. Molher's Name (First, Middle, Maiden Sumame) 19.							1	☐ Yes 2	X No	Spec	ify:			I	Specifi	v: W	hite	
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Paymend Drival Julia Baker 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State, Zip Code)	Elementary/Secon	ndary (0-12)		College ((1-4or 5+)				_						Own :	Home	<u>.</u>	
19a. Informant's Namer Relationship (Type, Print) James HandLey/husband 1025 Stone Road Westminster, MD 21158 20a. Method of Disposition 19a Bard 2 Coremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Specific Specify Donation 5 Other (Specify) 221. Signature of Funeral Specific Specify Donation 5 Other (Specify) 222. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Batteven Onset failure. List only one cause on each line. 225. Person 19a Specific Specify Due to (or as a consequence of): 226. Deaction - City or Town, State Dother (Specify) 227. Was sidecedent pregnant in the past 12 mg/min? 1 Ves 2 EMO Due to (or as a consequence of): 228. Date of delivery Month Day Year Due to (or as a consequence of): 229. Due to (or as a consequence of): 230. Due to (or as a consequence of): 231. Specific Underlying the death) Last Due to (or as a consequence of): 232. If yes, outcome of pregnancy 1 Uve brint 2 Fetal death 5 Other (specify) Due to (or as a consequence of): 233. Date of delivery Month Day Year 1 Ves 2 EMO 9 Unknown 24a, Was an approve of the complete of cause of death 1 Ves 2 EMO 9 Unknown 24b, Was an approve of complete of cause of death 1 Ves 2 EMO 1	17. Father's Name (First, Middle,	Last)							18. M c	th <i>er</i> 's Na	ame (F	irst, Middi	e, Maide	n Surnan	ne)		
19a. Informant's Namer Relationship (Type, Print) James HandLey/husband 1025 Stone Road Westminster, MD 21158 20a. Method of Disposition 19a Burst 2 Cremation 3 Removal from State 20b. Please of Disposition (Name of Verter Place) 19a Burst 2 Cremation 3 Removal from State 20b. Please of Disposition (Name of Verter Place) 19a Burst 2 Cremation 3 Removal from State 20b. Please of Disposition (Name of Verter Place) 19a Burst 2 Cremation 3 Removal from State 20b. Please of Disposition (Name of Verter Place) 19a Burst 2 Contact State 20b. Please of Disposition (Name of Verter Place) 19a Burst 2 Contact State 20b. Please of Disposition (Name of Verter Place) 19a Burst 2 Contact State 20b. Please of Disposition (Name of Verter Place) 19a Burst 2 Contact State 20b. Please of Disposition (Name of Verter Place) 19a Burst 2 Contact State 20b. Please of Disposition (Name of Verter Place) 19a Burst 2 Contact State 20b. Please of Disposition (Name of Verter Place) 19a Burst 2 Contact State 20b. Please of Disposition (Name of Verter Place) 19a Burst 2 Contact State 20b. Please of Disposition (Name of Verter Place) 19a Burst 2 Contact State 20b. Please of Disposition (Name of Verter Place) 19a Burst 2 Contact State 20b. Please of Disposition (Name of Verter Place) 19a Burst 2 Contact State 20b. Please of Disposition (Name of Verter Place) 19a Burst 2 Contact State 20b. Please of Disposition (Name of Verter Place) 19a Burst 2 Contact State 20b. Please of Disposition (Name of Verter Place) 19a Burst 2 Contact State 20b. Please of Disposition (Name of Verter Place) 19a Burst 2 Contact State 20b. Please of Disposition (Name of Verter Place) 19a Burst 2 Contact State 20b. Please of Disposition (Name of Verter Place) 19a Burst 2 Contact State 20b. Place of Disposition (Name of Verter Place) 19a Burst 2 Contact State 20b. Place of Disposition (Name of Verter Place) 19a B	Darmon	A Destro	11								nali:	a Ra	akor					
James Handley/husband 1025 Stone Road Westminster, MD 21158		_		Print)		19b.	. Mailing	Address	Street					ber, City	or Town,	State, Z	(ip Code)	
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All Washington Road Westminster, MD 21157	1 🔀 Burial 2 [Cremation		noval from	State						5,	/18/	/2004		Tayl	orsv	ille,	MD
All Washington Road Westminster, MD 21157	21. Signature of Fu	neral See ice	Licensee		1		26	Name true	Aggre	net Fa	chity Ho	nme	and	Chan	el.	P.A.		
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IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 1 1 1 1 1 1 1 1	23a. Part1. Enter the shock, or hear	ne disease, o nt failure. Lis	r complica t only one	tions that cause on	caused the deach line.	death. Do r	not ente										Interval Be	tween
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23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?, 1 Yes 2 No 3 Probably 4 Unknown 25. Was case referred to medical examiner? 1 Yes 2 No 3 Probably 4 Unknown 26. Place of Death (Check only one) 27. Manner of Death Sending Sendi			d															
1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year			230	if ves. or	itcome of pr	agnancy									224 Da	to of dali	uan.	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknown 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 Winknown 25. Was case referred to medical examiner? 1 Yes 2 No 3 Probably 4 Winknown 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No Yes 2 Yes 2 No Yes 2 Yes				1∐Live	birth 2 🗌	Fetal death												Year
24a. Was an autopsy performed?, 1 Yes 2 No 3 Probably 4 Winknown 25. Was case referred to medical examiner? 1 Yes 2 No 3 Probably 4 Winknown 26. Place of Death (Check only one) 27. Manner of Death Service of Injury (Month, Day Year) 28. Date of Injury 28b. Time of Injury 4 Work? 28. Date of Injury 28b. Time of Injury 4 Work? 28. Date of Injury 4 Norsing Home 5 Residence 6 Other (Specify)	1 □ Yes 2 €					or death	5 🗀	Other (spe	спу)									
24a. Was an autopsy performed? 25. Was case referred to medical examiner? 1 Yes 2 No 3 Probably 4 Onknown 26. Place of Death (Check only one) 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28c. Injury at Work? 28d. Describe how injury occurred	Part II. Other signif	icant condit	ions contri	buting to d	death but no	resulting in	the un	derlying ca	use giv	en in Pa	irt 1.		23e. Did	tobacco	use cont	ribute to	the cause of	death?
25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending 28b. Time of Injury 1 Note: 28c. Injury at Work? 28c. Injury at Work? 28d. Describe how injury occurred													1	Yes 2	! □ No	3 🗆 Pro	obably 4 🖃	nknown
25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 28a. Date of Injury 1 Notural 5 Pending 28b. Time of Injury 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 4 Nursing Home 5 Residence 6 Other (Specify)												ĺ	24a. Wa	s an	24b	Were au	topsy findings	available
25. Was case referred to medical examiner? 1												-	aut per	opsy form <i>e</i> d?		death?		cause of
examiner? 1 Yes 2 No															0	1 ∐ Yes	2LJ-N6	
27. Manner of Death 1 Sea. Date of Injury (Month, Day Year) 28b. Time of Injury 1 Nursing Home 5 Hesidence 6 Other (Specify) 28c. Injury at Work? 4 Nursing Home 5 Hesidence 6 Other (Specify) 28d. Describe how injury occurred Work?	examiner?	1		enital:					Oth	ac.								
M 1 Vac 2 No				1 [·		1	*-	Nursing						cify)	
	1 Natural	5 🗌 Pendi	ing	28a. Date (Mor	of Injury nth, Day Yea						□No	280	I. Describe	∍ how inju	iry occur	red		

MINTH

within 24 hours after death. To the Funeral Director: A

Physician /Medical **Examiner**

> 31. Date filed (Month, Day, Year) State Registrar

Medical Certification; To Be Completed by Physician/Medical Examiner

2 Accident

3 🗀 Suicide

29a. Certifier

4 Homicide

BINU

29b. Signature and title of certifier

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

neral Director: After this certificate has been signed by the attending physicien filled in by the funeral director, page 2 should be detached for use as the buria

VITACKO

30. N. me and address of person who completed cause of death (Item 23a) (Type, P int)

20

6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

52030

		-	For Stata Registrar	State of I	Maryland / D	epartme Certifica					giene neg. No. 2	11. 1821	, <u>r</u>
	Physici		1. Decedent's Name (First, Middle, I							2. Date of Dea Month May		(ear	A M
	/Medio		Joseph Brian HAI 4a. Facility Name (If not institution, g		er)	4b. City	, Town, or	Location (of Death	пау	4c. County of		
	Examin	er	19103 Poffenberg				21740)			Washir	ngton	
	Funeral Director				Age (In yrs. last birth 76 Y	nday) If Und Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day July 2	7 Year) 0, 1927	9. Birthplace (State or Fo Country) Maryland	reign
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Li	imits
	Maryla f sho	ō		agton	Нао	erstow	n					1 ☐ Yes 2 🕅	No
	r 28a-	Director	Maryland Washin 10e. Street and Number	igcon	inag		p Code				10g. Citizen of Wh	at Country?	
	th with		19103 Poffenber	ger Road			21	740			U.S.A.		
Maryland 21215-0036	72 hours after death with the Maryland Insturet, or Items 23s or 28s-f show dital Examinar must be mulliked at	by Funeral	11. Marital Status 1 □ Never Married 2 ☼ Married 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 17 Yes 2 If Yes, Give Year or Date	es? □No	13. Was Dec If Yes, sp		ispanic Ori in, Mexicar Specify:		cify Yes or No- Rican, etc.)	14. Race Black, Specify:	Americen Indian, White, etc. White	
2-0	72 hours naturel',	ted	15. Decedent's (Specify only highest of	Education orade completed)	16a. 0	Decedent's Us (Give kind of w life. DO NOT	ual Occupa	ation during mos	st of working	ng	16b. Kind of Bus	ness/Industry	
2	within 72 ho piene. r than "natur the Medical	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	iii. DO NOT Assemb1		1)			Manufac	rturing	
2	e filed w Il Hygier other ti vent, th		9 17. Father's Name (First, Middle, La	0	<i>F</i>	Assembl	er	18. Mothe	er's Name	(First, Middle,	Maiden Sumame,		
au	og ig b og	To Be	Henry William H					Le	lia W	hisner			
ary	S E E	۲	19a. Informant's Name/Relationship		19b.	Mailing Addre	s (Street	and Numb	er or Rura	Route Numbe	r, City or Town, S	tate, Zip Code)	
	5 - N -		Janet L. Harris	- Wife		19103 P		nberg				Md. 21740	
Baltimore,	T of		20a. Method of Disposition 1	☐Removal from Sta	20b. Place of cemetery	Disposition (N v, crematory or	ame of other plac	(e)	D	ate		ity or Town, State	
Ë	permit. Pages Department of I Important: If its Imp injury or of DDCB.		`4 □Donation 5 □ Other (Spe	cify)		Hill Ce			5/20/			own, Marylan	nd
3all	Depart Import Import Inn in		21. Signature of Funeral Service Lie	ensee		22. Name			112		Funeral I	Home Md. 21740	
	40244		23a. Part1. Enter the disease, or co	emplications that cau	sed the death. Do no							Approximate Interval Between	
	Pnysician /Medical Examiner	ner	shock, or heart failure. List or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Due con	as a consequence o		a	lelle	omA	q lur	ys	Organ and Deat	3
68760,	tificate be executed ig physicien and as the burial-transit	edical Examiner	Cause (ulsease or injury that initiated events resulting in death) Last	c. Due to (or	as a consequence o	f):							
P.O. Box (The law requires that the death certifica tte has been signed by the attending phoge? should be delached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 Fetal death	3 □Ectopic 5 □ Other (23d. Date Mont	•	
	quires that n signed b uld be deta	ed by Pl	Part II. Oth ignificant on	s contribu i g to dea	th but not resulting in	the underlying	cause giv	en in Part I	I. 			oute to the cause of death	
I Records,		Completed by									sy med? de	ere autopsy findings avai or to completion of cause ath?] Yes 2 2 No	lable of
Vital	Physician: Th this certificate ral director, peg	Be	25. Was case referred to medical examiner?	Hospital:			Oth			(Check only or	-		-
of	문 후 교	5.	1 Yes 2 Ho	1 🗀 Inp	nationt 2 ER/Out		28c. Injur Wor	4 🗆 141	ursing Hor		ence 6 Other low injury occurred		
o G	ding h. After fune	tion	1 Natural 5 Pending 2 Accident investiga	28a. Date of (Month,	Day Year) In	ijury M		k? Yes 2. □]No				
Division	of or Attending after death. I Director: After d in by the fune	Certification;	3 Suicide 6 Could no 4 Homicide determin	200. Flace 0	f Injury - At home, far I, etc. <i>(Specify)</i>	m, street, facto	ry, office		2	28f. Location (5 City or Tow		or Rural Route Number,	
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	Medical C			est of my knowledge, is of examination and r stated.							ner as stated. d due to the cause(s)	
		W	29b. Sign were and title of certifier	how, mi		Ď	9c. Licens 366	e number		ni	29d. Date signed	(Month, Day, Year) 2004	
34	1-4+1		30. Name and address of person w	ANTIEDA	of death (Item 23a) (Type Brint)	HA	gus	trux) m	3 217	40	
		ate rar	31. Date filed (Month, Mar, Yea)	0 2004 ^{32. Ra}	Istrar's Signature	Spar	2						

			Amend Items 25,27 1. Decedent's Name (First, Middle, Last)	State of Ma ,26a-f per	ME,G832,06/0	ariment o i (Oudhb rtiricate d	of Death	and N	1ental Hy		004	3 Time of Treating
	Physicia /Medic		Carl Leon Hull							24, Day 200	O 4 ear	9:30pm
A	Examin		4a Facility Name (If not institution, give s Williamsport N	treet and number) Iursing	Home				sport		of Death ningt	on
	Funeral Director		100 10 1702		(In yrs. last birthday) 88 Yrs.	If Under 1 You Months Da	ear If Unde ays Hours	r 24 Hrs. Min.	8. Date of Birt (Month, Da Apri	v. Year)	9. Birthpla Country	ce (State or Foreign y) MD
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo						100	d. Inside City Limits
	e Mary	cto	MD Washingt	on	William	sport						1X Yes 2 □ No
	ter death with the Marylar frems 23e or 28e-f show incr must be notified at	al Dire	10e. Street and Number 154 N. Artizan	Street		10f. Zip Cod 21	^{de} 795			10g. Citizen of V		y?
020	72 hours after death with the Maryland natural; or items 23e or 28e-f show iteal Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 N If Yes, Give Year or Dates:	ver in U,S. 13.	Was Decedent If Yes, specify 0 1 ☐ Yes 2 🛣			ecify Yes or No Rican, etc.)	14. Rac Blac Specify	ce - American ck, White, et whi	c.
21215-0020		Be Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece (Give	dent's Usual Oc kind of work do DO NOT use re	ccupation one during mo	st of work	ing	16b. Kind of Bi		-
212	within piene.	ошо	Elementary/Secondary (0-12) 12th grade	College (1-4or 5-	-1	urity				Equip		
	ges 1 and 2 should be filed within it of Health and Mental Hygiene. If Itam 27 Is marked other than or other traumatic event, the Ma	Bec	17. Father's Name (First, Middle, Last) Gilbert Presto	n Hull	Cr					Maiden Suman		
Maryland	should nd Mer marke	٩	19a. Informant's Name/Relationship (Typ.			ng Address (St				er, City or Town,		Code)
-	and 2 saith ar	Ì	Robert R. Hull	Sr.	10	904 Ke	mper					MD 21795
Baltimore	Pages 1 and the nent of He nent of He nent if Itan		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Dispo cemetery, crea St. Paul	osition (Name or matory or other Cemet	ery F	eb.2	Date 6,2004	20c. Location -	City or Town	n, State ring, MD
Balt	permit. Page Department of Important: If any Injury or pnce.		21. Signature of Funeral Service License	/-/	1	2. Name and Ad Donald	Dani.	d 171	ompson	Funer	al Ho	ome, Inc
Aug.	b		23a. Part1. Enter the disease, or complic shock, or heart allure. List only on	cations that caused e cause on each line	the death. Do not en	ter the mode of	dying, such es	s cardiac o	or respiratory ar	rest,	1D 41	Approximate Interval Between Inset and Death
1	Physician /Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death) a.	RESPIRA	ATORY	FAILL				11	1/4	Houzs
		ner		Pulmon:	oue to (or as a consec	quence of):	ANA	SARC	^A	1 / 25	ENAMER	WEEKS
	and and Il-transi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to for as a consec		1	0.1	11/1	A I BY ME		
68760,	cete be execu physician and s the bunel-tra	S	that initiated events	STEROI	Oue to (or as a consec	MNVS	TRATI	0N	70/12	KKO.	6	WEEKS
Box 68	death certificate be executed the attending physician and ad for use as the buriel-transit	n/Medi	resulting in death) Last	SEVERE			PEMPH	iYG	CAR COM		Y	EARS
	0 0	sicia	Part II. Other significant conditions cont	ributing to death bu	t not resulting in the u	inderlying cause	given in Part	1.	23b. Did t	obacco use co	ntribute to t	he cause of death?
, P.O	res that the designed by the a	y Phy	DIATRETES MEL	LITUS					10	Yes 2 No	3 ☐ Proba	bly 4 ☐ Unknown
Vital Records,	requi	Completed by Physician/M	CEREBIONALU CA	HR DIS	SEASE				24a. Was perfo	an autopsy rmed?	avail	autopsy findings able prior to pletion of cause ath?
H R	The ete h page	Co	QUADRIPARESIS	DUE TO	5 000 C	ERVICA	L FRA	TURE	101	ree aldino	10	Yes 2□ No
	Physician: r this certific rral director,	o Be	25. Was case referred to medical examiner?	ospital:	nt 2 ER/Outpatier	2 DOA	Othor		n (Check only o	<i>ne)</i> lence 6 □Oth	or (Cassifu)	
J Of	g Phy er this	n: To	27. Manner of Death	28a. Date of Injury (Month, Day		f 28c. I	Injury at Work?		28d. Describe h	ow injury occur		
Division	Attanding in death. Setor: After by the fune	catic	2 Accident investigation 3 Suicide 6 Could not be	1994	Unknow	n M	1 □ Yes 2 🖸		Subject f	ell Street and Numb	or or Pumil	Pouto Mumbor
Divi	lor At efter o Direct d in by	Certification:	4 Homicide determined	building, etc.	ry - At home, farm, str (Specify)	reet, factory, off	ice		City or Tow	m, State)		stown, MD
	To the Hospital or Attandli within 24 hours efter death. To the Funeral Director: A completely filled in by the to	edicai C	29a. Certifier (Check only one) 1 ✓ Certifying Physic 2 ☐ Medical Examin	cian: To the best of	f my knowledge, deatl examination and/or in ed.			nd place, a	and due to the	cause(s) and ma	anner as stat	ted.
	To the within To the compl	M	29b. Signature and title of certifier	JIM			cense number	^		29d. Date signe	d (Month, Da	ay, Year)
			TEGOWY.	mpleted across of di-	ath /item 22s) /Tv	Drint)	5370°	0	eo, ru	Februar	125,	2004
i	#12		30. Name and address of person who cor	7542 0	JUERLOOK	DE,	ZOUN	Bot	20, 14)	•	
	Sta		31. Date filed (Month, Day, Year) FFR 2 6 2004		r's Signature	ile						

			1 - State Registrar AMEND ITEM	State of Ma #21 PER FH						Reg. Ne2	004	18247
	Physicia		1. Decedent's Name (First, Middle, La Carolyn B. Harse						2. Date of De Month	ath Day 18	2004	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, gir	ve street and number)		1		r Location of Death		4c. Co	unty of Death	
			PENINSULA REGION				If Under 1 Year	4/364111 If Under 24 Hrs.	9 Date of Bir		NICOM!	
	Funeral Director		224-74-2912	Sex 7. Age 1 M 2	(In yrs. last b	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Dec 7,	19, Year) 1952		ace (State or Foreign try) MD
X	laryland show		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Loc	ation				10	Od. Inside City Limits
9,	ath with the Maryla 23a or 28a-f show	ctor	MD Worces	ter	Pocom	oke		*				1 ☐¥es 2 ☐ No
8	or 28a-f	Dire	10e. Street and Number				10f. Zip Code				of What Coun	try?
Z.	eath w	erai	806 4th Street	12. Was Decedent E	Ever in II S	13 V	21851	dispanie Origin? (Sr	pecify Yes or No	U.S	S. Race - America	an Indian
ار الا	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I Health and Mental Hygiene. I Health and Mental Hygiene. Other traumatic event, the Medical Examinar must be notified a	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Yes, specify Cuba ☐ Yes 2 ☑ No	dispanic Origin? (Span, Mexican, Puerto Specify:	Rican, etc.)		Black, White, e	etc.
y 224 21215-0036	n 72 hours • natural' • Jical En	Completed	15. Decedent's E (Specify only highest gr	rade completed)		(Give I	ent's Usual Occup kind of work done OO NOT use retired	during most of work	king	16b. Kind	of Business/Ind	dustry
	2 should be filed within and Mental Hygiene. I is marked other than raumatic event, I a Mental Menta	Somp	Elementary/Secondary (0-12)	College (1-4or 5-	+)		Molde	er			Plasti	cs
Maryland 2	d be fill antal Hy red oth	Be	17. Father's Name (First, Middle, Las Samuel E. Hall	t)				18. Mother's Nam	ne (First, Middle an A. Bi	_	name)	
<i>%</i> ∑	should and Me mark umath	2	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailin	g Address (Street	and Number or Ru			wn, State, Zip	Code)
	Health a tem 27 Is		Anthony Harsey/h	usband	8	06 4	th St.,	Pocomoke,	MD 218		ion - City or To	Citta
がなダル Baltimore.	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 [`4 □ Donation 5 □ Other (Spec	□Removal from State		-	sition (Name of patory or other place	_{сө)} Сет 4/24/			dtown.	
MKOUY ■ Baltimo	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Lice	ensee		_22	Name and Addre	ss of Facility	7			OL.
	20 = 6 0		LEWIS N. WATS 23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused	the death. Do	16 not ente	18 West	Rd., Sali	sbury,	MD 218	301	Approximate Interval Between
	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a ACU	ITE	MY	OCAR	DIAL	INFA	RCT	TON	Interval Between Onset and Death
	Examiner			Due to (or as a	a consequence	e of): EA	IAL F	FATLU	RE			
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a		•	< U \(\alpha \)	V				
Ö	be executed sician and burial-transit		that initiated events resulting in death) Last	c. Due to (or as a	a consequence	e of):	SHOC			0		
68760.	icate be physicia s the bu	edicai		d. CORI	ONAI	RY_	ARTE	RY I	<u> 215E</u>	ASE		
O. Box 6	ath certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		Ectopic pregnanc Other (specify)	у		23d	. Date of delive Month	ry Day Year
× d	res that the de signed by the a	by Pr	Part II. Other significant conditions					-				e cause of death?
# Cord	w require been si should b	70	CHRONIC OB	STRUCT	VE P	UIM	ONARY.	DISEAS		Yes 2□N		
Œ	The law ate has b	Complete							24a. Whas auto perfo 1 \(\text{Yes}		prior to con death? 1 Yes	osy findings available inpletion of cause of 2 No
Si.		Bec	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only	one)		
75	hys this al di	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Hipatie		Outpatien . Time of	t 3□ DOA Ott		ome 5 Resi			')
Ĵ. C	nding f tth. : After e funer.	ation	1 Natural 5 Pending 2 Accident investigate	28a. Date of Injur (Month, Day	y Year)	Injury	Wo	rk?]Yes 2□No	200. 000000	.,		
	l or Attance after death Diractor: I in by the	Certification:	3 Suicide 6 Could not determine		ury - At home, c. (Specify)	farm, str	eet, factory, office			Street and N wn, State)	umber or Rura	l Route Number,
2	To the Hospital or Attanding within 24 hours after death of To tha Funeral Director: After completely filled in by the fune	Medical C		Physician: To the best of aminer: On the basis of and manner sta	f examination a							
	To the within To the complete	Me	29b. Signature and title of certifier	2			29c. Licens	se number		29d. Date si	igned (Month, L	Day, Year)
	/(_		AX	a	ME	>		6334		APRI	L, 19	114 2004
	MC		30. Name of address Ferson who	o completed cause of de		(Туре, 400	Print) EAST	ERN SI	DOLL D	RS	SAUShu.	IN MD
	Sta Regist		31. Date filed (Month, Day, Year) APR 2 3		ar's Signature	6	Spor	ERN SI	2	1801		1

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

			State of Maryland / Department of Health and 1- State Registrar Certificate of Death		giene2004	18249
			Decedent's Name (First, Middle, Last)	2. Date of Deat Month		3. Time of Death
	Physicia /Medic		Emma Elizabeth Haines	۵5	31 04	2:20 P.M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deal	th	4c. County of Death	
			Sacred Heart Hospital Cumberlan	1	ALLEG	
	Funeral Director		5. Social Security Number 6. Sex 1 Months 2 Mg F 8 8 1 Nrs. last birthday) 1 Under 1 Year 1 If Under 24 Hrs Months Days Hours Min	(Month, Day,	Year) Cou	place (S l ate or Foreign ntry) 7
		}	Usual Residence of Decedent	Apr. 1	, 1921 WY	
	nylanc how	. [10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	e Ma	cto	WV Mineral Keyser			1 √Yes 2 No
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show the Modical Examiter must be notified at	Director	10e. Street and Number	1	0g. Citizen of What Cou	•
	sath v	Fai		Specify Ven or No.	14. Race - Ameri	
	fter d	Funerai	Armed Forces? If Yes, specify Cuban, Mexican, Puer 1 □ Never Married 2 □ Married 1 □ Yes 2 🛣 No	to Rican, etc.)	Black, White,	
8	al', o	by	If Yes, Give 1 ☐ Yes 💯 No Specify: Year or Dates:		Specify: wh	ite
20	72 hc 'natur	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of wo	rking	16b. Kind of Business/Ir	ndustry
12	within nne. han '	mpi	Elementary/Secondary (0-12) College (1-4or 5+) 12th Sales Clerk		Torre 1 mm	
i D	filed v Hygie other t	ပ္		me (First, Middle, I	Jewelry Maiden Sumame)	
<u>a</u>	should be nd Mental marked o	To Be		G. McGu		
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic avant, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R	ural Route Number	, City or Town, State, Zij	Code)
Σ	and 2 salth a n 27 ls	3	John R. Haines/son 1355 Cornell Stre			
ore	of He		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State		20c. Location - City or T	
Ē	Pag tment tant: jury c		'4 □Donation 5 □Other (Specify) Potomac Memorial 6/4	1/04	Keyser, W	V
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If itam 27 Is any injury or other trau 2008.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Markwood Funera P.O. Box 912 Report Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	1 Home,	Inc.	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	c or espiratory arre	est,	Approximate Interval Between
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₽.	that the ed by detac	H-	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to t	he cause of death?
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Division of	al or Attending P : after death. I Diractor: After t d in by the funera	Certification:	4 Homicide determined 286. Place of injury - At nome, farm, street, factory, office building, etc. (Specify)	City or Town		ar noble reamber,
	To the Hospital or Attanding Physician: The law within 24 hours after death. To tha Funaral Diractor: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifler (Check only Check only Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the basis of examination and/or investigation, in my opinion, death occurred at the basis of examination and/or investigation, in my opinion, death occurred at the basis of examination and/or investigation, in my opinion, death occurred at the basis of examination and/or investigation, and the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of	e, and due to the ca arred at the time, da	ause(s) and manner as s ate and place, and due to	tated. o the cause(s)
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DHMH 17 Rev 1/2001

ician		I. Decedent's Name (Fir		, Last) NES								2. Date Mont MAY	h	Day 2004	Year	3. Time of Dea 7:40
dical		LEWIS RAY			d numbei	r)		4b. City,	Town, or	r Location	of Death	PIZZI	24,	1	ty of Death	7:40 2
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al or		5. Social Security Number 215–26–694	44	6. Sex 1 🛣 M 2 🗆		Age (In yrs. 87	: last birthda Yrs.	y) If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date (Mont AUG	of Birth h, Day, 17,	1916	9. Birthi Coul MARY	place (State or Fo http:/ LAND
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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 31 2004 Ella Elizabeth Jarrett May 9:40 P /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington 14260 Tollgate Ridge Hancock If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

December 8,1916 Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🖫 F 87 DE Director 222**-**12-8267 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 27 le marked other than "natural", or iteme 23e or 28e-f ehow traumatic event, the Mudical Examinar must be nigitified at 1 Yes 2 No Funeral Director Washington Hancock 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number death with 21750 USA 14260 Tollgate Ridge 12. Was Decedent Ever in U.S. Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 te marked other than "natural", or Ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 XMarried 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify. Specify: ð 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Maude Mudeira Harvey Matthews 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 le any injury or other trau once. 14260 Tollgate Ridge Hancock, MD 21750 Junius G. Jarrett/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4- Donation 5 ☐ Other (Specify) 06/03/04 Gracelawn Memorial Park New Castle, DE 21. Signature Funeral Serv 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Pert1. Enter the disease, or complicates is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dementia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐ Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 2□No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 emesidence 1 Yes 2 No 6 ☐Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yeer) 27. Manne of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 56048 June 2, 2004 130 reet Hancock West High 31. Date filed (Mbnth) Day, Year) 31. Da . Registrar's Siggature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** May 24, Elizabeth Konrad 2004 10:50A M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Prince Georges 107 Bon Hill Drive Ft.Washington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 □ TF 003-32-3837 77 Yrs. 10, 1926 Czechoslovakia Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23a or 28a-f show the Medical Executiver must be notified at 1 ☐ Yes 2\(\)\(\)\(\)\(\)\(\) Maryland Prince George's Fort Washington Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20744 United States 107 Bon Hill Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2√ No If Yes, Give X X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√√√No Specify: White þ 3XXWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Business Bookkeeper other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental I wit: If Item 27 is marked o Josef Franz Hujer Ann Lange 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4106 Stratton Road, Temple Hills, Maryland20748 Elfriede Pace (friend) 20a. Method of Disposition

XX Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 28,2004 permit, Page Department o Important: If any injury or once. Maryland Veterans Cemetery Cheltenham, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service I 22. Name and Address of Facility Lee Funeral Home, Inc 663301d Alexandria Ferry Road, Clinton, Md 20735 23a. P. rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Phermonia /Medical Due to (or as a consequence of) Examiner Stroke Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Congestire the attending physicien and Due to (or as a consequence of) Completed by Physiclan/Medical -16 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy been signed by the atter should be detached for Day Year in the past 12 months? Month Yes 2 No 4☐Pregnant at time of death 5 Cher (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 20 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ★ esidence 6 ☐ Other (Specify) Certification: To 28b. Time of 28 escribe how injury occurred 27 Manner of Death 28a. Date of Injury (Month, Day Year) After 1 Natural 2 Accident 5 Pending To the nuespine after death, within 24 hours after death, To the Funeral Director: Af investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and tale of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0053219 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zafar Ansari, 7E Post Office Rd $_{
m MD}$. Waldorf, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 7 2004 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For State Registrar	State	of Marylar	•	artmen rtificat			and M	-	giene Reg. No.	200		2251
Physicia	an	1. Decedent's Name (First, Middle	, Last)							2. Date of Dea Month	Day	Year	3. Time	of Death
/Medic	al	Nancy L. Ka		number)		4h City	Town or	Location o	of Death	May	20 4c. C	2004 ounty of Deat	7.	/† M
Examin	er	4207 Winding Wa	•	iumoer)				minst			10.0	Carro		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birt (Month, Da May 1	th v. Yeer)	Co	nplace (State	or Foreign
Director		215-30-0524	1 □ M 2 🔯 F	72	Yrs.	MOITHIS	Days	Tiours		May 1	3' , 19:	32 Ma	arÿlan	d
land		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside	City Limits
Mary I sh	to	Maryland Cari	:011		West	ninst	er						1	s 2∏XNo
th the	Director	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What Co	untry?	
ath wi	ral	4207 Winding V					2115			76.24		ed Sta		
ter da Items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Marri	Armed	ecedent Ever in U Forces? s 2 (X No	J.S. 13.	Was Dece	ient of Hi cify Cuba	spanic Orig n, Mexican	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	- 14	. Race - Ame Black, White		
72 hours after death with the Maryland 72 hours after death with the Maryland natural, or Items 23a or 28a-f show after Examinar must be notified at	ģ	3 ☐ Widowed 4 ☐ Divorced	If Yes, O	Give Dates:		1 🔲 Yes	2 🔯 No	Specify:			S	pecify: Wh	ite	
ba filed within 72 hours after death with the Marylan tall Hygiene. Ad other than "natural", or liems 23a or 28a-f show event, the Medical Examinat must be notified at	Completed	15. Decedent		d)	16a. Dece	dent's Usua kind of wo	al Occupa	ation during most	t of worki	ng	16b. Kind	of Business/	ndustry	
within ne. than	ldu.	Elementary/Secondary (0-12)	College	(1-4or 5+)	life.	no not u Home:						Own Ho	me	
should ba filed within nd Mental Hygiene. I marked other than amatic event, the Mental Hygiene.		17. Father's Name (First, Middle,	Last)		1				r's Name	(First, Middle,				
lid ba lental ked c	To Be	Malcolm E. Rote	2					Cha	rlot	te E. L	ego			
2 shou and M is mai		19a. Informant's Name/Relations	nip (Type, Print)			•	•			l Route Numbe			ip Code)	·
1 and 1 Health Health tem 27 other tr		Mr. Dennis M. I	Cane Hus	sband	420 Place of Dispo			Way		tminste		tion - City or		
parmit. Pages 1 and 2 should ba filed within Department of Health and Mahala Hygiene. Important: If item 27 is marked other than any injury or othar traumatic event, II. Means once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation		m State	cemetery, crei	matory or c	ther plac	-		ay 21,				MD
nit. Pa artmer ortant injury		 4 □Denation 5 □ Other (S) 21. Signature of Funeral Service 		U.										гш
parmit. Departn Imports any injk		Janu 16	alle	100	B ₁	urrie 212 W	r-Qu	een F d Lib	uner erty	al Home Road W	. & Cr Tinfie	emator 1d,MD	y, PA 21784	
		3a. Part . Enter the disease, or shock, or heart failure. List	complications tha	caused the dea	th. Do not ent	ter the mod	e of dyin	g, such as	cardiac o	r respiratory ar	rrest,		Approxim Interval B	etween
Physician	1	Immediate Cause (Final disease or condition	a EN	xephalop	ally,	OWKN	auc	Etiolo	254				Onset and	wills
/Medical Examiner	,	resulting in death)	Due t	to (or as a consec	quence of):				//					
	er	Sequentially list conditions, if any, leading to immediate	b. — Due t	to (or as a consec	quence of):									
cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c											
cata ba exacuted by sician and the burial-transit	i Ex	resulting in death) Last	Due t	to (or as a consec	quence of):									
Invision of vital indext of the Hospital or Attending Physician: The law requires that the death cartificata ba exacuted within 24 brous after death. To the Funaral Director: After this certificate has bean signed by the attanding physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dlcai		d											
eath cartific attanding p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of pregn							230	d. Date of deli	very	
death death e atta	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No		e birth 2 Feta egnant at time of the		⊒Ectopic p ⊒ Other (sp						Month	Day	Year
at the	Phys	9 Unknown			- tale - in also -			in Bard I		220 Did to	obacca usa	contribute to	the cause of	Edonato 2
w requires that the de bean signed by the should be detached	þ	Part II. Other significent condition	ons contributing to	o death but not re	sulting in the u	inderlying d	ause give	en in Parti.			Yes 2□i			Unknown
v requ	Completed									24a. Was	an :	24b. Were au	tonsv finding	s available
he lav e has age 2	duic									autop	rmed? 2 10 No	prior to death? 1 ☐ Yes	ompletion of	cause of
ian: Tilical	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	213410	
hysic his ce il direc	To	1 ☐ Yes 2 ☑ No			ER/Outpatier			4 LI NU		me 5 🕩 Resid		□Other (Spec	eify)	
ding P	lon:	27. Manner of Death 1 ☐ Natural 5 ☐ Pendin 2 ☐ Accident investig		te of Injury onth, Day Year)	28b. Time o Injury	of M	8c. Injun Work	≀at <br Yes 2 ⊟1		28d. Describe h	now injury o	occurred		
Attendation of the	fical	3 Suicide 6 Could	not be 28e. Pla	ce of Injury - At h	nome, farm, st					28f. Location (5		Number or Ru	ral Route Nu	mber,
s after	Certification;	4 Homicide	Du	ilding, etc. (Speci	my) 					City or Tov	vn, State)			
To the Hospital or Attending Physician: The law within 24 buours after death. To the Funaral Director: Attent his certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medice)	g Physician: To the	basis of examin	owledge, deat ation and/or in	h occurred	at the tim	ne, date an pinion, dea	d place, a	and due to the	cause(s) ar date and pl	nd manner as lace, and due	stated. to the cause	(s)
thin 2, the long the	Med	one) 29b. Signature and title of gentifie	and m	anner stated.		29	c. License	number			29d. Date	Signed (Monti	, Day, Year)	
		Vaturel 1	U O Seel)					•					
WIL 3		30. Name and address of person	who completed ca	ause of death (Ite	m 23a) (Type,	Print)		- 0 - 0		o Ecl	/			7000
)		PATRICK TO	ents, up	54170	1.4 -	1000	o Li	BURT	y K	o Ecl	CHSK	WEG M	0 4	187
Sta Registr		31. Date filed (Month, Day, Year)	2 1 2nn4	. Registrar's Sign	ature '	1								

		1 - For State Registrar	State of Maryl		artment of rtificate of		R	og. No. 200	
Physicia /Medic Examin	al	Paul Kline III 4a. Facility Name (If not institution, give seems) 1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give seems)			4b. City, Town.	or Location of Deal	2. Date of Deal Month May	Day Year 17, 2004	6:05 A.
Funeral Director	ei	Williamsport High 5. Social Security Number 6. Sec	School School	rs. last birthday) Yrs.		iamsport	8. Date of Birth	Washing	
,	or	Usual Residence of Decedent 10a. State 10b. County Md . Freder	10c.	City, Town or Lo	cation ithsburg		Dec.17,	1947 Hai	10d. Inside City Lim 1 ☐ Yes 2X
Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examinaria and Le modified at once.	by Funeral Director	10e. Street and Number 3208 Garfield Rd.	12. Was Decedent Ever in Armed Forces? 1	n U.S. 13. 1	10f. Zip Code	1783 Hispanic Origin? (Span, Mexican, Puer		0g. Citizen of What C U • S • A 14. Race - Am Black, Wh Specify:	country?
Hygiene. other than "natura ent, the Modical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	cation	16a. Deced (Give life.	dent's Usual Occu kind of work done OO NOT use retire Custod	iduring most of wo ad) ian	rking me (First, Middle, N	16b. Kind of Business School	
and Mental F s marked of sumatic eve	To Be	Paul Kline Jr. 19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address (Stree	Sadi	e M. Hun		Zip Code)
artment of Health ortant: If Item 27 I injury or other tre		Carolyn J. Kline 20a. Method of Disposition 1 X Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21 Signature of Funeral Colors	emoval from State St	b. Place of Dispo cemetery, cren Mark!	sition (Name of natory or other pla S Luther	an May	20, 004 \	d. 21783 20c. Location - City o Wolfsville radbury Av	,Md.
hysician /Medical xaminer		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a con:	eath. Do not ent				urg,Md. 21	783 Approximate Interval Between Onset and Death
g physician and as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Littler Underlying Cause (Disease or injury that indiated events resulting in death) Last	Due to (or as a cons		,				
ned by the attending detached for use a:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3	Ectopic pregnanc Other (specify)	zy		23d. Date of de Month	olivery Day Year
igne be d	by	Part II. Other significant conditions con	stributing to death but not	resulting in the ur	nderlying cause g	ven in Part I.	1 □ Ye	s 2 No 3 P	_
r death. actor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Be Completed	25. Was case referred to medical examiner?				26. Place of Dea	24a. Was ar autops perform 1 Yes 2	y prior to death? ZNo 1 ☐ Yes	utopsy findings availa completion of cause s 2 No
£ 18	Certification: To	27. Manner of Death 1 Platural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - A		28c. Inju Wo M 1		lome 5 Reside 28d. Describe ho 28f. Location (Str.		ural Floute Number
4 hou Funer ely fill	edical Certi	29a. Certifier 1 Certifying Phys	building, etc. (Special stress of my ner: On the basis of examples	ecify) knowledge, death	occurred at the t	ime, date and place	City or Town	, State)	s stated
	Med	29b. Signature and title of certifier	And manner stated.		29c. Licen	se number	29	9d. Date signed (Mon	th, Day, Year)
10	te	30. Name and address of person who con Vincent A. Cartono 31. Date (iled (Month, Day, Year)	mpleted cause of death (100 (Type 23a) (Type 23a)	Print) PHE150	n Blud	Smiths	3/19/ buym	2/783

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registret MEND TTEM #8&9 PER FH G832 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** sephine MAY 22 1230PM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1105) PITAL ENSTON MEMORIAL TALBOT If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months 222-18-80 1 □ M 2 1 Days Hours Min. Yrs. APRIL 28,1910 Director DELAWRE Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. fnside City Limits or 28a-f ahow other traumatic avant, the Medical Examiner must be notified at y Yes 2 No Director Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States or Items 23a 21629 1027 South Heritage Court death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No 1 ☐ Never Married 2 Married Maryland 21215-0036 Specify: Caucasian If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 Divorced 'natural' 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any ridury or other traumatic avent, the Mean JORGE. Efementary/Secondary (0-12) Coltege (1-4or 5+) Sewing Seamstress 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Malinda Zebley 2 Joseph James Keeley, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1027 South Heritage Court, Denton, Maryland 21629 Walter G. Kerslake, Jr. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 5/27/2004 Wilmington, Delaware Silverbrook Cemetery 21. Signature of Funeral Service L 22. Name and Address of Facility
Moore Funeral Home, P.A.
12 South Second Street, Denton, Maryland 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate fnterval Between Onset and Death Immediate Cause (Finaf Physician Dirotton pneumonia one week disease or condition /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 attending physicien Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregrant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 mon 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by page 2 should be 2 PNo 3 ☐ Probabfy 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 Yes 2 No 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred medical examiner? fur eral director, Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Dinpatient Certification: To 2 ER/Outpatient 3 DOA o this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Alter Division 1 Matural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide pelli Hospitel Medical 29a. Certifier i 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person wh completed cause of death (Item 23a) (Type, Print) MO henna 32, Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

25

JUSEPHIN

KERSLAKE

ORIGINAL

	rts.			State of Maryland / C per dvr 6832 6/			•	_	18256
					Certificate of	Death		No. 5/29/04	
	Physici	an	Decedent's Name (First, Middle, Last)				Month	Day Yeer	3. Time of Death
	/Medic		Joe Vernon Knable		41. Ch. T		May	9 2003	•
	Examin	er	4a. Facility Name (If not institution, give s			or Location of Death		4c. County of Death	
			13778 Orchard Ridg 5. Social Security Number 6. Sex		Hancock		8. Date of Birth	Washingt	
	Funeral Director		1.10	M 00 F	Yrs. Months Days		July 15,1	932 MD	place (State or Foreign intry)
			220-28-8086 Usual Residence of Decedent				July 13,1	932 MD	
	yland		10a. State 10b. County	10c. City, Towr	n or Location				10d. Inside City Limits
	Mar.	Director	MD Washingt	on Hanc	ock				1 ☐ Yes 2 X No
	or 28	lre	10e. Street and Number		10f. Zip Code		10g	Citizen of What Cou	intry?
	23a	al	13778 Orchard Rid	ge Road	21750)		USA	
	r des	Funeral	The state of the s	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
36	hours after death with the Maryland lurel', or Itams 23a or 28a-f show at Exartiner must be rudified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 □ No If Ye s, Give Year or Dates:	1 ☐ Yes 2 📉 No	Specify:		Specify:	
8	ba filed within 72 hours after death with the Marylar Ital Hygiene. ed other than "natural", or itams 23a or 28a-f show event, the Madical Exercipal mast be notified at		15. Decedent's Educ		Decedent's Usual Occup	nation	161	b. Kind of Business/Ir	ite
15	in 72 in mat	olet	(Specify only highest grade	completed)	(Give kind of work done life. DO NOT use retire	during most of worki	ing	b. Itilia of baomicoan	loadily
7	a filed within al Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	sembler		Ai	rcraft Par	cts Mfg.
b	i filed I Hygi other ent, I	a l	17. Father's Name (First, Middle, Last)	, 10	DCINDLCI.	18. Mother's Name	(First, Middle, Mai		
lan	should ba nd Mental marked o	To B	Lewis Condie Knabl	۵		Olive V	Robinson	,	
Maryland 21215-0036	2 shoul and Me is mark aumati	_	19a. Informant's Name/Relationship (Type		Mailing Address (Street				o Code)
Σ	コピト		Rosie M.Knable/Wife	. 13	778 Orchard	l Ridge Ro	ad Hancoc	k,MD 21750	00
Baltimore,	of Healt of Healt litem 2 r other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R		Disposition (Name of y, crematory or other pla	ice)	Date 200	c. Location - City or T	own, State
Ē	Page nent c		* 4 □Donation 5 □ Other (Specify)	smoval from State Stone	Bridge Ceme	tery 06/02	2/04 Hai	ncock.MD	
alti	permit. Pages 'Department of H Important: If ite any injury or of		21. Signature of Funeral Service License		22. Name and Addre			West Main	Street
<u>m</u>	89 = 29		Kall	XVIII	Grove Fune	ral Home,	P.A. Hance	ock,MD 217	′50 – 0368
Е			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death. Do r	not enter the mode of dyin	ng, such as cardiac o	or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Luni	Charee				Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence	of):				
	Examiner		Sequentially list conditions.						
)	D #	Examiner	Sequentially list conditions, and leave the cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	of)ir				
)	and -trans	Kam	that initiated events resulting in death) Last	. Due to (or as a consequence of	of):				
760,	te ba executed ysician and ie burial-transit	cal E		Due to (or as a consequence t	51).				
687	<u>~</u> ~ ~		d						
9 X	n certificat anding phy use as th	Physiclan/Med	IF FEMALE: 2	3c. If yes, outcome of pregnancy				23d. Date of deliv	en/
Вох	atten for u	clan	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	y		Month Month	Day Year
o	at the de by the stached	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	J _ Other (Specify) _				
P.O.	de Ba		Part II. Other significant conditions con	tributing to death but not resulting in	the underlying cause giv	ven in Part J.	23e. Did tobac	co use contribute to t	he cause of death?
Records,	uires sign	d by					1 ☑ Yes	2 No 3 Prot	bably 4 Unknown
CO	w require been si should b	Completed					24a. Was an	24b. Were auto	opsy findings available
Re	The law cate has page 2 s	mo					autopsy performed	prior to co	mpletion of cause of
Vital		e Cc	25. Was case referred to medical			26. Place of Death	1 Yes 2	No 1 ☐ Yes	2 No
⋚	Physician: this certificatal director, I	o B	examiner?	lospital: 1 ☐ Inpatient 2 ☐ ER/Ou	tnatient 30 DOA Oth			e 6 □Other (Specia	6/1
of	P = la	P .	27. Manner of Death	28a. Date of Injury 28b. 1	Time of 28c. Injur	ry at	28d. Describe how		y/
ion	Attending I or death. ector: After by the funer	ation	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) li	njury Wo M 1 ☐	rk?]Yes 2 □No			
Division	f or Attendii after death. Director: A	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office		28f. Location (Stree City or Town, S	t and Number or Rura	al Route Number,
	s afte	Certification:	4 - Homeloa	building, etc. (Specify)			Ony or 10mm, 0	naio/	
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Phys	sician: To the best of my knowledge	o, death occurred at the to	me, date and place,	and due to the caus	e(s) and manner as s	itated,
	the H in 24 the F iplete	ledical	one)	and manner stated.					``
	To To Con	Σ	29b. Signature and title of certifier	00 1	29c. Licens	se number	29d.	Date signed (Month,	Day, Year)
ţ			muchael of.	Mulaund A	10 0	41667		5.29.0	14
	5		30. Name and address of person who co	mpleted cause of death (Item 23a) (MCCornack 32. Registrar's Signature 0 8 2014	(Type, Print)	1- 1 /-	1~	,	100
			31. Date filed (Month, Day, Year)	32 Banistraria Simatura	11(10 Mes	lice / Can	nou la	1500 Nun	MD.
	Sta Registi		. IIIN	1 8 2014	M. Ann	0. 8			
			V011	CO COURSES	JU ATTENDED	Balanda .			

		Stete Registrar Decedent's Name (First, Middle, Last	")	Ce	rtificate of D	leath	2. Date of Da		2004	3. Time of Death
Physici		Betty Agnes King					Month May	14^{Day}	2004 ear	7:30 A.
/Medic		4a. Facility Name (If not institution, give			4b. City, Town, or L	ocation of Death		4c. C	ounty of Deeth	1
		18131 Zion Rd.			Marydel				aroline	
Funeral Director		5. Social Security Number 244-40-9122 Usual Residence of Decedent	x □M 2XIF 74	rs. last birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Bird Month, Da 11-24-2	y. Year)	9. Birthp Cour North	place (State or Foreintry) Carolina
Mon		10a. State 10b. County	10c.	City, Town or Lo	ocation				1	10d. Inside City Limi
P-fell	to	Maryland Carolin	e i	Marydel						1 ☐ Yes 2 💢 1
or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Cour	ntry?
23a		18131 Zion Rd				1649			S.A.	
He m	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No	n U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto I	cify Yes or No Rican, etc.)	- 14	. Race - Americ Black, White,	
of, or	by F	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🕅 No	Specify:		S	pecify: Wh	nite
ical E	Completed by Funeral	15. Decedent's Edu		16a. Dece	dent's Usual Occupati	on		16b. Kind	of Business/In-	dustry
Wed or	nple	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done du DO NOT use retired)	ring most of workii	19			
T T	Col	12		Hor	memaker				home	
even	Be	17. Father's Name (First, Middle, Last)			1	8. Mother's Name		Maiden Su	итате)	
Department of results and Mental Hygiene. Unportant: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Once.	2	Wiley Sanders 19a. Informant's Name/Relationship (T)	una Printl	10h Maili	ng Address (Street an	Leila		on City on T	Town Chair Ti-	. (2-4-1)
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tem 2		20a. Method of Disposition		b. Place of Dispo	osition (Name of	. D	ate		tion - City or To	own, State
y or		1 XBurial 2 ☐ Cremation 3 ☐ 1 Donation 5 ☐ Other (Specify)	Le	wn Crof		5/20/	2004	Linwo	ood, PA	
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/sician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o tmmediate Cause (Final disease or condition	lications that caused the dine cause on each line.	eath. Do not en	ter the mode of dying,	such as cardiac o	r respiratory ar	rest,	,	Approximate Interval Between Onset and Death
ledical aminer		resulting in death)	Due to (or as a cons	sequence of):						1
hysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b			,		-		
y the attending physician and iched for use as the burial-transit	cal	resulting in death) Last	cDue to (or as a cons	sequence of): gnancy etal death 3[□Ectopic pregnancy			230	d. Date of delive	ery Day Year
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	B Ma	cto	MD Car	roll		Westmi	ınster						1 XYes 2 No
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Baltimore,	parmit. Pagas 1 and 2 s Dapartmant of Haalth ar Important: If Item 27 is any Injury or other trau phce.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		ate	Place of Dispo cemetery, cren inganor	natory or oth	er place)	5	Date /17/200	20c. Location	City or Town	
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>	G S	2	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Ing	atient 2] ER/Outpatient	3□ DOA	Other: 4	Nursing Hon	ne 5□Resio	dence 6 □Oth	er (Specify)	
on of	ing Afta funa		27. Manner of Death 1 ☑ Naturel 5 ☐ Pending	28e. Date of (Month,	Injury <i>Dey Year)</i>	28b. Time of Injury	28c	Injury at Work? 1 ☐ Yes		28d. Describe h	now injury occur	red	
	or Atten aftar daa Director: in by the	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Plece of	Injury - At h , etc. (Speci	ome, farm, stre				28f. Location (5 City or Tow	Street and Numb m, Stete)	er or Rural F	Route Number,
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D	111/	M	29b. Signature and title of certifier	MD	Juliou.			icense numb			29d. Date signed	d (Month, Da	1y, Year) 200 K
	WJS		30. Name end eddress of person who	completed cause	of deeth (Her	m 23e) (Type, F	Print) Ave	nue	we	stmeny	ta	MD 2	1157
-\$5	Sta Registr		31. Dete filed (Month, Day, Year) MAY 1	32. Reg	istar's Signa	ature	/						

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 29DM 10 Carroll James 4c. County of Deeth City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and numb Maryland Baltimore City renera DITA Birthplece (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) 6. Sex Days Hours Min **№** 2 🗆 F Yrs. ORANGE Va. 225-66-6119 57 4-28-1947 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 □ No Baltimore City Md. Baltimore City 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 906 Argyle Ave. 21201 United States Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 11. Marital Status Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 🎽 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Tractor Tmailer Driver 8 None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Carroll Long Sr. Geneva Elizabeth Graves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susie Long 189 Oakbrook Apt. P.O.Box 1055 Orange, Va. 22960 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Madison Crematory 6-3-04 Madison, Virginia. 22 Name and Address of Facility 21. Signature of Funeral Service Licenses Treddy Preddy Funeral Home 250 W. Main St. Orange, Va. CC0204 23a. Part. Enter the disease, or complications (hat caused the death. Do not enter the mode of dying, such as cardiac or respiralory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) o (or as a consequence of): Due to Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. Il yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an Were autopsy findings available prior to completion of cause of prior to completion death? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Impatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

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Completed

Funeral

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item 27 is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Madical Examinar must be notified as

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anding physicien and use as the burial-transit The law requires that the death certificate be executed ō signed by the a need has rector, page 2 or Attending Physician: director death. the à after within 24 hours of To the Funeral ro the Hospital

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Physician/Medical Examiner

Certification:

25. Was case referred to medical examiner?

27. Menney of Death 2 Accident 3 Suicide

4 Homicide

29a. Certifie

5 Pending

investigation 6 ☐ Could not be determined

Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f: Location (Street and Number or Rural Route Number, City or Town; State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29b. Signature and/title of certified

MD

General

29d. Date signed (Month, Day, Year)

of person who completed cause of death (Item 23a) (Type, Print)

31. Date liled (Month, Day, Year) State Registrar

JUN 0 8 2014



State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** May 21 John Michael McGovern 2004 16:07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 X M 2 □ F Yrs 22. 1948 Washington D.C. 55 Director 218-52-7764 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28e-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Modical Examinational be notified at 1 Tyes 2 No Directo Damascus Maryland Montgomery 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number 20872 United States 10630 Bethesda Church Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify þ 3 ☐ Widowed 4 ADivorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) H.V.A.C. Steamfitter 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Mary Virginia Hamann John Joseph McGovern 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 Murdock Road, Baltimore, Maryland 21212 Kristyn M. Hurley/ Daughter uepurtment of He Important: If itam any injura 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, State 20a. Method of Disposition 5/27/2004 1 ☐ Burial 2 XCremation 3 ☐ Removal from State `4 □Donation 5 □ Other (Specify) Alexandria, Virginia Metropolitan Crematorium Inc 21. Signature of Juneral Service Licensee permit. Depurtn 22. Name and Address of Facility Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or e cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence **Examiner** LEN65 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown Be Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: 1 TYes 1 Inpatient 2 R/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After or Attanding 1 Vatural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Exeminer: On the basis of examination and/or investigation in my opinion, death accurred at the To the Hospital 29a. Certifier Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 101 Shady Grove Adventist Hospital, Rockville, Maryland 20882 William Dooley M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY

Evan Moffitt 04-03307 RPD

PD			1 - For State Registrar	State of	of Maryla		ertment of hertificate of		nd Men		ene g. No. 20	04	18261
			1. Decedent's Name (First, Middle	, Last)						Date of Death		Vasa	3. Time of Death
	Physici /Medic		Evan Th	omas Moff	fitt				M	lay 16,	2004	Year	0156 А м
	Examin		4a. Facility Name (If not institution Johns Hopkins I		ımber)		4b. City, Town, o Baltimo		Death		4c. County		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday) If Under 1 Year Months Days	If Under 2 Hours		Date of Birth Month, Day,	Year)	9. Birth	place (State or Foreign
	Director		211-72-2008	1⊠M 2□F	1	2 Yrs.	Months Days	Hours	Fe	eb. 11	1992		Ä
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. C	City, Town or L	ocation						10d. Inside City Limits
	aho	ō	,	1 1	1.56.								1 ☐ Yes 2 ☑ No
	28a-1	ect	Maryland Car	roll		westm	inster 10f. Zip Code			10	g. Citizen of	A/5A C	
	with a or	ā		D				157		10			•
	eath	era	2196 Timothy		edent Ever in	U.S. 13	Was Decedent of H		in? (Specify	Ves or No.	United		can Indian,
10	r Itan	표	1 ☑ Never Married 2 ☐ Marri	Armed Fo	orces?		If Yes, specify Cub	an, Mexican,	Puerto Rica	n, etc.)		ck, White,	
8	al', o	þ	3 Widowed 4 Divorced	If Yes, Gi Year or D	ive Dates:		1 □ Yes 2 ☑ No	Specify:			Specif	v: Wh:	ite
5-0	ilied within 72 hours after death with the Maryland Hygione. Hyerinen "natural", or Itams 23a or 28a-f ahow ith, Ita Medical Evanirar must be redilled at	Completed by Funeral Director	15. Decedent (Specify only highes			16a. Dece	edent's Usual Occup e kind of work done	oation	of working	1	6b. Kind of B	usiness/Ir	ndustry
21	ithin nan "	npl	Elementary/Secondary (0-12)	College (life.	DO NOT use retire	d)	or morning				
2	led w lygier her ti		6th 17. Father's Name (First, Middle, I				Studen						Middle
anc	t be find the of or or over	Be			Tas			18. Mother			aiden Suman	ne)	
Ē	hould d Me mark matic	ဥ	William M 19a. Informant's Name/Relationsh		., Jr.	10h Mail	ing Address (Street	and Number		e E. S		State 7	Code
Maryland 21215-0036	ith an 27 is 1 trau		M/M Bill Moffit		s	1	Timothy				er, MI		157
	es 1 and of Health f item 27 r other ti		20a. Method of Disposition		20b.	Place of Disp	osition (Name of matory or other pla	7	Date		Oc. Location -		
e E	Page ent o nt: If ry or		1 ☑Burial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (Sp				er Ch. Ce	·	y 20 2	2004	Manche	ster.	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tier az is marked other than "natural; or flams 23a or 28a-f ahow any injury or other traumatic event, the Medical Examination must be notified at once.		21. Sign dure of Funeral Service I		7				-				
m	Depa Impo any ir	i (i	Lame 1	19 Cc	un		2. Name and Address Name and Name a	ueen Fi ld Lib	uneral ertv R	Home	& Crem	ator	y, P.A. 21784
			232. Part 1. Enter the disease, or shock or heart failure. List	complications that conly one cause on e	caused the de	ath. Do not er	ter the mode of dyir	ng, such as c	ardiac or res	piratory arres	st,		Approximate Interval Between
	Physician .		Immediate Cause (Final disease or condition	Con	tact s	hotgur	1 wound	to he	ad				Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conse	quence of):							
		1	Sequentially list conditions,	b. Due to	(or as a nonse	owenes of							
	nsit	mine	cause. Enter Underlying Cause (Disease or injury	300.0	(01 40 4 101100	quonos sij.							
Ć,	execun and ial-tra	Examiner	that initiated events resulting in death) Last	c	(or as a conse	quence of):							
58760,	rcate be executed physician and s the burial-transit	dical		d									
D	rtifica ng ph	a)	IF FEMALE:	1			-						
Вох	eath certific attending p	an/I	23b. Was decedent pregnant in the past 12 months?	23c. Il yes, ou 1□Live b	tcome of pregr		☐Ectopic pregnancy	/			23d. Dat Mo	e ol delive	ory Day Year
0	The law requires that the death certif tie has been signed by the attending bage 2 should be detached for use a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregr 9□Unkn	nant at time of own	death 5	Other (specify)			·	MIO	11(11	Day 19ar
٥.	that the sed by detac		Part II. Other significant conditio	ns contributing to d	eath but not re	sulting in the	underlying cause giv	en in Part I.		23e. Did toba	cco use cont	ribute to tl	ne cause of death?
Records,	uires that signed t	d by		· ·		•	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						ably 4 Dunknown
COL	w requir been si should l	lete								24a. Was an	24h 1	Nere auto	psy findings available
Ä	he tar e has age 2	Completed								autopsy performe	ed?	prior to co death?	mpletion of cause of
_		a	25. Was case referred to medical					26 Place o		eck only one		2 Yes	2∐ No
Division of Vital	ysici is cer direct	To B	examiner? 1X Yes 2 □ No	Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 DOA Oth	00			ce 6 □Oth	er (Specifi	v)
0	ig Ph ter th neral		27. Manner of Death	28a. Date	of Injury th, Day Year)	28b. Time o	The second secon				injury occurr		"
0	andin path. or: Af	atic	1 □Natural 5 □ Pending 2 □ Accident investig	ation Man I	e 2004	12:10	AM 1	Yes 2⊠No	o sul	bect sh	ot sel	t	
N N	r Atte	ertification:	3 Suicide 6 Could n 4 Homicide determi	ned 286. Place	of Injury · At I	nome, larm, st	reet, factory, office			City or Town.	State)		l Route Number,
	ital o	Cer				house			22 4	tahm R	oad, we	estrall	rster, min
	To the Hospital or Attending Physician: within 24 hours alter death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical	(Check only 24 Medical E	Physician: To the xaminer: On the b	asis of examin	owledge, dea ation and/or in	th occurred at the tire to the	ne, date and pinion, death	place, and d occurred at	ue to the cau the time, date	se(s) and ma e and place, a	nner as st and due to	ated. the cause(s)
	thin 2 the orthodorum	Med	29b. Signature and title of certifier	and man	ner stated.		29c. Licens	e number		290	I. Date signed	(Month	Day Year)
				Green	ann A	In	0.0.1				y 16,		,, , , , , , , , , , , , , , , , , , , ,
	WIL		30. Name and address of person v										
	- (Tasha Z Gr				111 Pen	n Stre	et, Ba	ltimor	re, Mar	ylan	d 21201
	Sta Registr		31. Date filed (Month, Day, Year) M \(\Delta \begin{array}{cccccccccccccccccccccccccccccccccccc	0 2004	egistar's Sign	nature 🎍	1						

The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760, attending physician or Attending Physicien:

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

naturel',

Director: within 24 hours after To the Funerel Dire

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

athleen W Sum M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stern MD 610

are

D32073

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Brunswick, Md. 21716

State Registrar

Medical

29a. Certifier

Kathleen

31. Date filed (Month, Day, Year) MAY 18 2004

W.



WIL

			1 - For State Registrar	State of N	Maryland / [Departme <i>Certifica</i>			ind M		iene	04	18263
	Physici		1. Decedent's Name (First, Middle, La Paul Brill MIMNA					-		2. Date of Deat Month May 21	Day	Year	3. Time of Death 9:00 a.M
	/Medio Examir		4a. Facility Name (If not institution, giver 18003 Par Three		or)	4b. Cit		Location of		1149 21	4c. County	of Death	
Ī	Funeral Director		5. Social Security Number 6. S 214–28–0263	ex 7 I⊠M 2□F	Age (In yrs. last bii 72	Yrs. If Und	er 1 Year		24 Hrs.	8. Date of Birth (Month, Day, Aug. /,			lace (State or Foreign try) Sylvania
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Washing	ton	10c. City, Tow Hager	n or Location						10	0d. Inside City Limits
	th with the 23a or 28a at be noti	ai Director	10e. Street and Number 18003 Par Three			10f. Z	ip Code	21740		10	0g. Citizen of V U . S		try?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. I health and Mental Hygiene item 27 is marked other then "natural", or Items 23e or 28e-1 show other traumetic event, the Medical Eventhet must be redified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	12. Was Decede Armed Force 1 XYes 2 [If Yes, Give Year or Date:	nt Ever in U.S. s? 1952 7 54			ispanic Orig in, Mexican, Specify:	jin? (Spe Puerto I	cify Yes or No- Rican, etc.)		e - Americ k, White, c	
Maryland 21215-0036	within 72 ho ene. than "natur he Medical I	Completed	15. Decedent's E (Specify only highest grant only highest grant only Secondary (0-12)		or 5+)	Decedent's Us (Give kind of w life. DO NOT	ork done d use retired	during most)		ng	federa		dustry ernment
land 2	12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic evant, the Mes	To Be Co	17. Father's Name (First, Middle, Last Paul Brill					18. Mother	's Name	(First, Middle, M Elizabet	faiden Sumam	Θ)	Climent
	ss 1 and 2 sho of Health and P item 27 is ma r other traume		19a. Informant's Name/Relationship (Jeffrey Mimnall -		18	3032 Put	ter 1		, Hag	Route Number,	, Mary	Land	21740
Baltimore,	t. Page rtment o rtant: If njury or		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ 1 □ Other (Special 2). Signature of Funeral Service Lices	y)	te cemete	f Disposition (N. ry, crematory or Haven C	other plac emete	· 1	Мау 20	04		own,	Maryland
Ba	permi Depa Impo any ir		23a. Part 1. Enter the disease, or com	Ranke	ed the death. Do	415	E. Wi	1son	B1vd	.,Hager		Md. 2	21740
1	Pnysician /Medical Examiner	er	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Due to (or a	as a consequence		ho	hles	tuc	leul	Clnie	1.	Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or a	as a consequence	of):							
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death at time of death	3 □Ectopic 5 □ Other (s					23d. Date Mon	e of deliver	ry Day Year
rds, P	w requires that been signed t should be deta	by	Part II. Other significant conditions of	ontributing to death	but not resulting in	n the underlying	cause give	en in Part I.	_	23e. Did tob			e cause of death?
of Vital Records,		Completed								24a. Was an autopsy perform	ed?	Vere autop rior to comeath?	sy findings available pletion of cause of
	Physic this ceral direct	ion; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpa 28a. Date of In (Month, L	iury 28b. 1	Time of njury	28c. Injury Work	at	sing Hom 2	(Check only one ne 5 🗆 Resider 8d. Describe how	nce 6 □Othe		
Division	tan leat tor: the	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	9 28e. Place of I	njury - At home, fa etc. (Specify)	rm, street, facto		∕es 2 □ N	-	8f. Location (Str. City or Town,	eet and Numbe State)	er or Rural	Route Number,
	To tha Hospital or At within 24 hours after d To tha Funaral Direct completely filled in by	Medical ((Check only 2 Medical Exar	ysician: To the basis niner: On the basis and manner	of examination an	d/or investigatio	n, in my op	inion, death	place, a	d at the time, da	te and place, a	nd due to	the cause(s)
	e≣e8	-	29b. Signature and title of certifier		At	1	C. License	362	23	29	d. Date signed	7.1	ay, Year)
7	X		30. Name and address of person who 31. Date filed (Month, Day, Year)	KASSII	LML	1111 01	nee	heel	Cer	pus !	Zet 11	ezer	stown ma
	Sta Registr	1.5	MAY 2 4 20	104 tre	Je St.	Spell							

			1. For State			Department o	f Health and I	Mental Hyg	jiene		10001
			Registrar			Certificate of	or Death	2. Date of Dea	-	104	10204
	Physicia /Medic		Decedent's Name (First, Middle, Last Margaret Virgit		tia Me	entzer		Month May	20 Z	2004	3. Time of Death 7:43 P M
Ì	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Tow	n, or Location of Death	ו	4c. County	of Death	
			Charlotte's Home				gansville		1	Washin	
1	Funeral Director		5. Social Security Number 6. Se 1 [X 7. Age	90		ear If Under 24 Hrs. lys Hours Min.	8. Date of Birth (Month, Day Sept.3, 1	913	Countr	ce (State or Foreign y) and
7	2		Usual Residence of Decedent 10a, State 10b, County		10c City Toy	vn or Location				100	d. Inside City Limits
9	sho	5			100. Ony, 10.						1 □ Yes 2 No
1	28a-f	Directo	Maryland Washing 10e. Street and Number	дтоп]	· · · · · · · · · · · · · · · · · · ·	Boonsbor			log. Citizen of	What County	v?
4	a or :	ក់		Dille		101. 210 000			og. Omzon or		y ,
4	18 23	era	7609 Sharpsburg	12. Was Decedent B	ver in U.S.	13 Was Decedent	of Hispanic Origin? (S	pecify Yes or No-	14. Rac	USA ce - America	n Indian.
1	He He	Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ N		If Yes, specify (of Hispanic Origin? (S Cuban, Mexican, Puert	o Rican, etc.)	Bla	ck, White, et	tc.
2	10.14		3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2💢	No Specify:		Specif	y: W	hite
5	illey with 7.5 hours are bean with the wayyand Hygiene. the than "natural", or Itema 23a or 28a-f show int, the Medical Examinat must be notified at	Completed by	15. Decedent's Ed	ucation	168	a. Decedent's Usual Oc	cupation	rkina	16b. Kind of B	usiness/Indu	ıstry
7	Med Ne	pje	(Specify only highest grad	College (1-4or 5	+)	life. DO NOT use re	one during most of wor stired)	King			
7	gien erth	5	12	2		Homema				Home	
	d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Suman	ne)	
2	od Menl	ပ	Frisby Tilton	Gray	1		Mary				lberger
ן מ	and is m raum		19a. Informant's Name/Relationship (7			b. Mailing Address (St			-		
5	and lealth m 27 her t		Frank Mentzer - S	son		7609 Sharps		Date	20c. Location		21713
5	rages net of thinks. If its nry or of		20a. Method of Disposition 1 Bunial 2 remation 3			of Disposition (Name of ery, crematory or other				•	
	tmen tant: njury		'4 □Donation 5 □Other (Specify	7	Smiths	burg Crema				⊿ r g,Ma	ryland
0	permit. Fages I and a should be filled within 7.2 fillouts after beath with the warylan pergarment of Health and Mental Hybine. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic svent, the Medical Examinar must be notified at 90ce.		21. Signature of Funeral Service Licen	1)8/1/			Funeral Ho				21795
	102 4 4		23a. Part. Enter the disease, or comp	lications that caused	the death. Do		conococheac			port,M	aryland Approximate
			strock, or heart failure. List only of	one cause on each lin	10.	A A	A	or respiratory arr	031,		interval Between Onset and Death
A .	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Conqu	less he	ant fai	in			1	2 day
	Examiner			Due to pr as	a consequence	of):					
		ē	Sequentially list conditions, if any, leading to immediate	bDue to (or as a	a consequence	o of);					
3	ansit	ᄪ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
,	executed in and ial-transit	Examiner	resulting in death) Last	Due to (or as	a consequence	of):					
ō .	DE CE OF	cal	(d							
0	cennicale iding phys ise as the	ledi								1	-
Š .	in cer iendir r use	an/A	23b. was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		h 3 ⊟Ectopic pregn	ancy			ite of deliver	
	s dealn he atten ed for u	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at 9□ Unknown	time of death	5 ☐ Other (specifi			MC	onth D	Day Year
ر ا	d by the	Phy	9 Unknown			in the deal in a serie	anna ia Bad I	220 Did to	haasa usa saa	tabuta ta tha	cause of death?
ທົ່	requires mat the een signed by th hould be detache	by	Part II. Other significant conditions of	ontributing to death bu	at not resulting	in the underlying caus	given in Part I.				bly 4 Dinknown
ecords	neen s hould	Completed	eno-siege de	mealle							
ပ္ မ	has b	nple						24a. Was a autop: perfor	SV	Were autops prior to com- death?	sy findings available pletion of cause of
	cate h									1 ☐ Yes 2	P.□ No
VITAL	Certifi ector	Be	25. Was case referred to medical examiner?	Hospital:			Other	ath (Check only or			
ō i	this ald	- To	1 Yes 2 No	1 ☐ Inpatie		Time of 28c.	4 Nursing H	lome 5 Resid			
<u>.</u>	After After fune	tion	1 Natural 5 ☐ Pending	(Month, Da)	Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No	200. 00001100 11	ow injury occur		
Division	deat deat ctor: y the	ertification:	3 Suicide 6 Could not be	28e. Place of Inju	ury - At home, f	farm, street, factory, of		28f. Location (S	treet and Numb	ber or Rural	Route Number,
ב ב	after after Dire	erti	4 Homicide	building, etc	c. (Specify)			City or Tow	n, State)		
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	aC				ge, death occurred at the					
	n 24 h	edical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examination a ited.	nd/or investigation, in	my opinion, death occu	irred at the time, o	late and place,	and due to t	he cause(s)
0	To the comp	ž	29b. Signature and title of certifier			29c. Li	cense number	2	29d. Date signe	d (Month, D	ay, Year)
į.	_		My			D 3	2518		5-21-0	24	
1	7-1		30. Name and address of person who	completed cause of d	eath (Item 23a					1	
2	`		21 Wyand	Drive	, kee	gregely	MO 2	1756	5-21-0 R-G1	TEDENI	1, 119
	Sta	ate	31. Date filed (Month Pay Vea 2	2004 32. R Sistra	ar's Signature	Bruke					/

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician MILDRED METTERNICH May DASPIT 30, 2004 1:00 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3640 Jarrettsville Pike Monkton Harford If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 3/17/1916 6. Sex Birthplace (State or Foreign Country) Funeral Days Hours 1 M 2 F Months Yrs. Director 438-14-1916 88 Louisiana Usual Residence of Decedent with the Merylend 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits f Health end Mentel Hygiene. Item 27 Is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Madical Examiner must be notified at or items 23a or 28a-f show 1 ☐ Yes 2 No Funeral Director MD. Harford Monkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3640 Jarrettsville Pike 21111 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. filed within 72 hours efter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: ģ Specify: 3 ☐ Widowed 4 1 Divorced ear or Dates White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Joseph Frank Daspit Alida Marie Leonard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21111 19a. Informant's Name/Relationship (Type, Print) of Health e Susan M. Kuhn/Daughter 3640 Jarrettsville Pike Monkton, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of H important: If Iter any injury or oth 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Roselawn Mem. Park 2004 Baton Rouge, LA. 22. Name and Address of Facility 21. Signature of Funeral Service License Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, 23a. Part1. Enter the disease, or complications that caused the heath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner by Physician/Medical Examiner ettending physicien end for use es the bunel-transit The lew requires that the death certificate be executed Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DEMENTIA Division of Vital Records, P.O. Box 68760 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown cete has been signed by pege 2 should by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate 1 ☐ Yes Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 2 No 1 Yes 4 Nursing Home 5 Residence 6 □Other (Specify) 2 ER/Outpatient 3□ DOA 27. Manner of De Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 No 1 Tes 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

RAVITEMID.

2014

JUN 08

32. Registrar's Signature

LUNG CURNER RUAD WHITE HALL M D 2116

			State of Maryland / Depart	ment of Health and M	Mental Hygien	e
		4	FOR	ficate of Death	Reg. N	2001 10000
			Decedent's Name (First, Middle, Last)		2. Date of Death Month D	3. Time of Death
	Physicia /Medic	al .	MADELINE X. NORRIS			2004 1.14 PM
	Examin		Tall Comity Hamile (in 1981 months)	b. City, Town, or Location of Death		c. County of Death
			10467 Peterboro Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Woodstock Under 1 Year If Under 24 Hrs.	8. Date of Birth	ontry) 9. Birthplace (State or Foreign Country)
	Funeral Director		214-16-2652 1 M 2X F 95 Yrs.	fonths Days Hours Min.	(Month, Day, Year June 19,1	
3	2		Usual Residence of Decedent 10a State 10b County 10c. City, Town or Locat			10d. Inside City Limits
School	show a show	7	10a. State 10b. County 10c. City, Town or Locat Woodstock 10c. City 10c. City, Town or Locat 10c. City, Town or Loc			1 ☐ Yes 2 No
Modi	28a-1	ecto	-	10f. Zip Code	10g. C	itizen of What Country?
Account with the Mandage	3a or		10467 Peterboro Road	21163		SA
4000	ms 2	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa Armed Forces?	s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Rece - American Indian, Black, White, etc.
0	or ite	Fu	1 Never Married 2 Married 1 Yes 2 No	Yes 2⊠ No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify: White
a z i z i 3-0036	fural',		3 Widowed 4 Divorced Year or Dates:	t's Usual Occupation	18b.	Kind of Business/Industry
	n "na	pleto	(Specify only highest grade completed) (Give kin	d of work done during most of work NOT use retired)	king	
7 7	Hygiene Sther the	Completed	8 Nurse			edical
ם ייי	d oth	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maide	
	market	P.	Harry Atkinson	Anna M Address (Street and Number or Ru	lary Kirby	<u> </u>
	S. I amus Should be bled within 12 hours after destit with the maryan item 27 is marked other then "natural", or items 23e or 28s-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print) Sharon Mangione-Granddaughter 65			
as :	Heall tem 2 other		20b. Place of Disposition			Location - City or Town, State
ō !	ages ent of nt: If i		1 ht Runal 2 Cremation 3 Hemoval from State		ne 3,2004	Frostburg, MD
Baltimore	permit. Pages Department of h important: If its any injury or of once.		21. Signature of Puneral Service Licensee (22. N	lame and Address of Facility		
מ	20 = 3		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the	fer Funeral S 02 National H	ervice, i wv. LaVa l	A MD 21502
			shock, or heart failure. List only one cause on each line.			Dittorvar Dotwood
	hysician		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic	Cardiovascul	er disea	se years
· .	/Medical Examiner		Due to (or as a consequence of):			Year
Н		er	Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying			
3	outed nd ransit	Examiner	cause. Enter Underrying Cause (Diseese or injury that initiated events c			
Ž	ate be executed hysician and he burial-transit		resulting in death) Last Due to (or as a consequence of):			
-	cate b physic the b	dlcal	d			
×	certifica Iding ph	//Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
ROX	death e atten ed for u	Iclar	in the past 12 months? 4 Pregnant at time of death 5 C	ctopic pregnancy other (specify)		Month Day Year
0	ires that the death certifical signed by the attending ph d be detached for use as the	Physician/Med	9 Unknown			
Ś	The law requires that the tite has been signed by thoage 2 should be detached.	by	Part II. Other significant conditions contributing to death but not resulting in the under Breast cancer (1984) (Don cancer		1 Tes	use contribute to the cause of death? 2 No 3 Probably 4 Defiknown
Records,	been si should	ompleted	Breast cancer (1984) Colon cancer	CIGITY)		
္မင္	has b	mple			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
		e Co		26 Place of Dea	th (Check only one)	1 ☐ Yes 2 ☐ HO
Vital	ysician: iis certific director,	o Be	examiner? Hospital:	Othor	ome 5 Residence	6 ☐Other (Specify)
ō	g Phy er this neral c	-		28c. Injury at Work?	28d. Describe how in	
oi o	uttending in death.	atlo	1 DNatural 5 Pending (Month, Day 1981) Injury 2 Accident investigation	M 1 Yes 2 No		
Division	l or Atten atter deatl Director: I in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	t, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
۵ .	Hospital or Attending Physician: 44 hours atter death. Funeral Director: After this certific lely filled in by the funeral director,			ccurred at the time, date and place	and due to the cause	(s) and manner as stated.
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investore) and manner stated.			
	To the within 2. To the complet	Me	295. Signature and title of certifier Deputy	29c. License number		Date signed (Month, Day, Year)
•			latya A yens ma	D31473		me 3,2004
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	int)	J Fillia	TCIA MO 21042
	Sta	to	PATRY CE A TOYE, MD 4565 HEM! 31. Date filed (Month, Day, Year) 32. Registrar's Synature	COCK CONE COM		
	Registi		31. Date filed (Month, Day, Year) 32. Registrar's Sanature JUN 0 9 2804	apartie !		
		004		1		

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** ELIZABETH Α. NORLEEN 1:30a JUNE 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14011 Gregg Neck Rd. Galena Kent 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Jan 28 Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 1 1 P 76 1928 577-36-8584 Director Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heath and Mental Hygiene.
ant: If item 27 is marked other then "naturel", or Itema 23a or 28a-f show ury or other traumatic event. If a Medical Examines must be notified at 1 ☐ Yes 2 X No Director MD Kent Galena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14011 Gregg Neck Rd. 21635 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) 12 Librarian Air Force 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unknown Willie 2 Elizabeth Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter A. Norleen (husband) P.O. Box 195 Galena, MD. 21635 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Eastern Shore 1 Burial _2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 6-7-04 *4 □ Donation 5 □ Other (Specify) Hurlock, MD. Veterans Cemetery 21. Signature of preral service Lic Galena Funeral Home of Stephen L. Schaech 118 West Cross St. Galena, MD. 21635 M00510 Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final **Physician** on Dur. resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I any, I admit to him ediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) detached P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, should be 1 Yes 2 10 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed, certificate 2 No 1 ☐ Yes Hospital or Attanding Physician: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) ို 2 ER/Outpatient 3 DOA this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 5 Pending investigation 1 Natural after death. м 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the ! 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pau1 Donaher, M.D. 119 C. North Main St. Galena, MD. 21635 31. Date filed (Month, Day, Year) 32. Registraris Signature State Registrar

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						24a. \	Vas an autopsy performed?	av	dere autopsy findings vailable prior to completion of cause death?
							I□Yes 2 🔼	11	□Yes 2□No
al					26. Place of	Death (Check o	nly one)		
Hospital: 1 □ I	Inpatient 2	ER/Outpatier	nt 3 DC	OA Othe	or: 4 Norsi	ing Home 5□ I	Residence 6	Other (Speci	fy)
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DHMH 16 Rev 6/95

			1 - For State Registrar	State of Maryl	and / Dep		t of H	ealth a		_	giene	004	18269
	Physici /Medio		Decedent's Name (First, Middle, La: Beulah Frances Pt						1	2. Date of De Month May	26ay	2004	3. Time of Death 8:45 P. M
	Examir Funeral		4a. Fecility Name (If not institution, given 2140 Aiken-Miller 5. Social Security Number 6. S	Road	vrs. last birthday)	If Under	2	Location of Accide If Under 2 Hours	ent	8. Date of Birt (Month, Da	h	Garr 9. Birthp	
	Director ***	or	219–18–5491 Usual Residence of Decedent 10a. State 10b. County	100	Yrs. City, Town or Le				9	Sept 10		O Mar	od. Inside City Limits 1 □ Yes 2 ♥□ No
	with the M ta or 28e-f	Direct	MD Garn 10e. Street and Number 2140 Aiken-Miller			10f. Zip	Code	ccider 1520	nt			of What Coun	
920	within 72 hours after death with the Maryland ene. then "netural", or Items 23a or 28e-1 show the Medical Evantian must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Deced If Yes, spec	lent of His		in? (Spec Puerto Ri	ify Yes or No- ican, etc.)	14. 5	Race - Americ Black, White,	
21215-0	d within 72 ho giene. Ir then "netur I're Medical I	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usua kind of wor DO NOT us	rk done d se retired)	uring most	of working	9	Hi-Y	Restaur of Bea	cant and
ıryland ;	should be filed Mental Hyg marked othe Imetic event,	To Be C	17. Father's Name (First, Middle, Last) Albert Reichenber 19a. Informant's Name/Relationship (cher				18. Mother Este	lla E		Maiden Sun		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygione. Important: If item 27 is marked other then "netural", or items 23a or 28e-1 show any injury or other traumetic event, the Medical Evant armst Le indiffed at once.		Margie Menges, S. 20a. Method of Disposition 1 [X] Burial 2 Cremation 3 C. 4 Donation 5 Other (Specify	ister 20		Nation (Nammatory or of	nal in the replace	Pike,	Gran	ntsvill	e, MD	•	6 wn, State
Balt	permit. Departimport any inj			euman	17	9 Mil	ler :	St., 1	РО Вс	ox 275,	Gran	Homes, tsville	
8760,	Attending Physician: The law requires that the death certificate be executed to Table 1. We will death. Sector: After this certificate has been signed by the attending physicien and properties of the funeral director, page 2 should be detached for use as the burial-transit and properties.	dical Examiner	23a. Part 1. Enter the disease, or construction of shock, or learn failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	s cell c						rest,		Approximate Interval Between Onset and Death 7 months
P.O. Box 68	ires that the death certific signed by the attending p d be detached for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₺ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	□Ectopic pre						Date of deliver	ry Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions c	ontributing to death but not	resulting in the u	nderlying ca	ause give	n in Part I.					e cause of death?
al Records,	n: The law re ficate has beo rr, page 2 sho	Completed	chronic obstruc	tive pulmona	ry disea	se			_	24a. Was a autop: perfor 1 Yes	sy med? 2 □ X No	b. Were autop prior to con death? 1 Yes	osy findings available apletion of cause of
Division of Vital	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	atlon; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time o		A Other Bc. Injury Work	4 🗌 Nurs	sing Home	Check only or 5 X Resid d. Describe h	ence 6 🗆 C	Other (Specify,)
Divis	in the	Certification:	3 Suicide 6 Could not be determined	building, etc. (Sp	ecity)					City or Tow	n, State)		Route Number,
	To the Hospitel within 24 hours a completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medicel Exen 29b. Signature and title of certifier	ysician: To the best of my niner: On the basis of exan and manner stated.	knowledge, deat nination and/or in	vestigation,	in my opi	nion, death	place, and occurred	at the time, d	ate and plac	e, and due to	the cause(s)
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	\0		30. Name and address of person who Walter K. Naumann	, M.D., PO Bo	ox 247,		emete	ery Ro	oad,	Accide	nt MD	21520	
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Si	-	Carried 1	P						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM #4 Reg. No. 2004 Certificate of Death WCHD/SH 6/3/04 per Informant 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month **Physician** May 18, 2004 11:40 P.M. Mary Anne Pavlovich /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner Washington | Hage Local | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 11, 1915 Julia Manor Health Care Center Hagerstown Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗓 F Yrs. 043-05-17351765 88 Connecticut Director Usuel Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City, Town or Location parmit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic evant, the Medical Examiner must be notified at 1X Yes 2 □ No Director Branford New Haven 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 06405 U.S.A 21 Toole Dr. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White Baltimore, Maryland 21215-0020 Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 12 College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Elizabeth Papp Steven Kruy 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20014 Rosebank Way #105 Hagerstown, Md. 21742 (Sister) Ann McElroy 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition May 26, 1 □ KBurial 2 □ Cremation 3 □ Removal from State St. Agnes Cemetery Donation 5 Other (Specify) 2004 Branford, CT. 21. Signature of Funeral Service License 22. Name and Address of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 enno ert1. Enter the disease, or compli-tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1□ Yes 2□ No this 28d. Describe how injury occurred 27. Menne of Deeth Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation I Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by To the Hospital or Att within 24 hours after of To the Funeral Direct completaly filled in by 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

31. Dete filed (Month, Day, Year) MAY 19 2004

ARID

29b. Signature and title of certifier

MURSHED 32. Rigistrar's Signature

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

1126 Opal Ct. Hagerstown, Md. 21740

00060396

					partment of Health and		ene	
		1	For State Registrar		ertificate of Death		. No. 2004 182	71
			Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year 3. Time of Deat	h
	Physicia /Medic	al .	Edwin Brooke Par			May	20, 2004 2:45 A.	М
)	Examin		4a. Fecility Name (If not institution, give str 16 Springfield I		4b. City, Town, or Location of Death Williamsport	ו	4c. County of Death Washington	
			5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,)		eign
	Funeral Director			1 2□F 76 Yrs.	Months Days Hours Min.	Sept. 16	1927 New Jersey	
	ס		Usuel Residence of Decedent	10c. City, Town or	Logation		10d. Inside City Lin	nits
	show	5	10a. State 10b. County				1 X Yes 2 □	
	the M	Director	Md. Washing	con	Williamsport		g. Citizen of What Country?	
	3a or		16 Springfield Lar	ie	21795		U.S.A.	
	death ms 2	Funeral			3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.	
9	or Ite	Fu	1 Never Married 2X Marned	1. Yes 2 No If Yes, Give /1 /	1 ☐ Yes 2 X No Specify:		Specify:	
ğ	filed within 72 hours after death with the Maryland Hygione. ther than "natural", or Items 23s or 28s-f show ant, the Medical Examination malified at	d by	3 Widowed 4 Divorced 15. Decedent's Educa	Year or Dates: 41-46	cedent's Usual Occupation	16	White Sb. Kind of Business/Industry	
5	in 72 n "na'	plete	(Specify only highest grade	Completed) (Gi	ive kind of work done during most of wo . DO NOT use retired)	rking		
212	filed with Hygiene other than	Completed	Elementary/Secondary (0-12)	4	C.P.A.		Government	
2	al Hy d other	Be	17. Father's Name (First, Middle, Last)			me (First, Middle, Ma		
<u> </u>	2 should be filed v and Mental Hygie is marked other t raumatic avent, III	2	Edwin Brooke Par		Verna Verna Address (Street and Number or Right)	Elizabeth		
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan to Health and Mental Hygiene. If the alth and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic avent, the Medical Examinatic rulat bu multified at		19a. Informant's Name/Relationship (Type Shirley A. Parkinso		Springfield Lane W		•	
	permit. Pages 1 and 2 Dep-riment of Health a Important: If item 27 i any njury or other tra once.		20a. Method of Disposition	20b. Place of Dis	sposition (Name of crematory or other place) May		Oc. Location - City or Town, State	
Baltimore,	Pages ient of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Denation 5 ☐ Other (Specify)	moval from State	ourg Crematory		Smithsburg, Md.	
a	permit. Departminimporta		21. Signature Funeral Service Licensee		22. Name and Address of Facility		dbury Ave.	
<u> </u>	\$9 E 2 9		Tennis /	. /	Davis Funeral Home		<u> </u>	
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. Do not cause on each line.	enter the mode of dying, such as cardia	c or respiratory arres	Interval Between Onset and Deat	
	Pnysician /Medical		Immediete Cause (Final disease or condition resulting in death)	Due to (or as a consequent and):	Modernam of	supem	and g mon	2/4
	Examiner		1	Due to (or as a consequence s).	watastic	Sundy	ome 6 mon	ths
		Je.	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	Due to (or as)a consequence of	popular inc.	11001		
	acuted ind transif	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	5				
760,	te be executed ysicien and ie burial-transit	cal Ex	resulting in death, cast	Due to (or as a consequence of):				
687	physicate Is	odlog	d.					
Box (that the death certificated by the attending phy detached for use as the	by Physician/Media	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of delivery	
	death	slcia	in the past 12 months? 1 ☐ Yes 2 ☐ No		5 Other (specify)		Month Day Year	
P.O.	at the	Phys	9 Unknown Part II. Other significant conditions cont		e underlying cause given in Part I	23e. Did toba	acco use contribute to the cause of death	?
	The law requires that the tite has been signed by thoage 2 should be detache		Part II. Other significant conditions con	induling to death but not resulting in the	e dilectiving couse given in tanti.	1 ☐ Yes		
of Vital Records,	v requ been shoulk	Completed				24a. Was an	24b. Were autopsy findings avail	able
Re	The lav	ошо				autopsy perform	prior to completion of cause ad2" death? ZNo 1 ☐ Yes 2 ☐ No	of
tal		BeC	25. Was case referred to medical		26. Place of De	ath (Check only one		
<u></u>	d S	To E	examiner? 1 ☐ Yes 2 No	ospital: 1 Inpatient 2 ER/Outpa			nce 6 ☐Other (Specify)	
n o	ing P		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Tim Inju		28d. Describe hov	v injury occurred	
Division	Attending r death. ector: Afte by the fune	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm	3		eet and Number or Rural Route Number,	
Di∧	after after I Direct	ertil	4 Homicide determined	building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town,	State)	
	To the Hospitel or Attending Ph within 24 hours after death To the Funerel Director: After thi completely filled in by the funeral	calc	29a. Certifier (Check only 2 Medical Examin	ician: To the best of my knowledge, d	leath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the car urred at the time, da	use(s) and manner as stated.	
	To the He within 24 To the Fe complete	ledical	one)	and manner stated.	29c. License number		d. Date signed (Month, Day, Year)	
	Viit To CO	Σ	29b. Signature and title of certifier	- Mass N	Al / L	12 1	25/21/01	
4			30. Name and address of person who col	mpleted cause of death (Item 23a) (Tv	rpe, Print)) Tou LON	140
16	X		Hind Hamas	11 ; CM, M	O OPAL CT	T. Ha	genitown, mo	TT
	St Regist	ate	31. Date filed (Month Pay Year) 4 21	32. Registrar's Signature	South			

DHMH 17 Rev 1/2001

ORIGINAL

		State of Maryland / Department of H Amend Item 25,27, 28a f per Me, 832 06/01/Adbb Certificate of I	lealth and Mental Hyd Death	giene 2004 18272
		1. Decedent's Name (First, Middle, Last)	2. Date of Dea	ath 3. Time of Death
	Physician /Medical	Velma B. Pattee	Feb.	Day 8, 2004 7:30 PM
	Examiner	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
		Salisbury Nursing and Rehab Center	Salisbury, Md.	Wicomico
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Date of Birt (Month, Da	y, Year) Country)
	Director	315-09-9013 AXF 86 Yrs. Usual Residence of Decedent	Aug 19,	1917 Liberty Ctr, IN
	ylend wor	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	h the Merylen r 28e-f ehow Indtilled al	MD Wicomico Salisbury		1 X Yes 2 □ No
	or 28e-f e	10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?
	123e or suit be real Dir	9288 Hickory Mill Road 21804		United States
	r tems 23 drar must Funeral	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of H	lispanic Origin? (Specify Yes or No- an, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
20	or effective or self.	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ② No If Yes, Give 1 ☐ Yes 2 ② No Year or Dates:	Specify:	Specify:
9		15. Decedent's Education 16a. Decedent's Usual Occurs	ation	White 16b. Kind of Business/Industry
215	hin 7.	(Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired Elementary/Secondary (0-12) College (1-4or 5+)	during most of working	The state of the s
21	ed within 72 ho ygiene. or than "natur it, the Medical Completed	12 House wife		Home
nd	be filed withing tall Hygiene. Id other than event, the M	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle,	
Za Za	should be filed and Mental Hyg marked other umatic event, To Be C	Calvin Hupp	Harriett (Dunaw	
PATTEE Maryland 21215-0020	12 sho h end r is me		and Number or Rural Route Numbe ce Church Road,	
e, P	s 1 end 2 should f Health end Mer tem 27 is marke other treumatic	20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City or Town, State
VELMA I	permit. Peges Depertment of i Important: If Its any Injury or o	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place	ce)	
Z E	ortani Injuri	4 Donation 5 Other (Specify) Tippecanoe Mem. G. 21. Signature of Emberal Service Licensee 22. Name and Address		Latayette, IN
B	permit. Depertr Importu any Inju	IT INCO	Melvin Fun	eral Home, 15522
	-	23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of duin	Highway, Harring	ton, DE 19952 rest, Approximate
0	Physician /Medical	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Immediate Cause (Final	s, seek at sarding of respiratory at	Onset and Death
	Examiner	disease or condition resulting in death) a. Presumme		1 Zweeks
		Due to (or as a consequence of):	////	
	cete be executed physicien end the buriel-trensit dical Examine	Sequentially list conditions. Due to (or as a consequence of):	NOT REPROVED BY MEDICAL COMMES	
0,	e exe	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury c	ONED BY MELT	1 1
8760,	certificate be executed ding physicien end ise es the buriel-trensit VMedical Examin	that initiated events resulting in death) Last Due to (or as e consequence of): CERTIFICATION Description:	nghippino	
, '8	n certific anding p use es	d	V	
7∼8				1
7.0	the day the sched	Part II. Other aignificant conditiona contributing to death but not resulting in the underlying cause give		obacco use contribute to the causa of death?
S, P	es thet igned b be dete by Pt	denita	1 D Y	res 2□ No 3□ Probably 4□ Unknown
	v requires thet the death been signed by the ette should be deteched for leted by Physicia	LL 1. C +	24a. Wes a	an autopsy 24b. Were autopsy findings
် ၀	The law require the law require the las been single 2 should Completed	right hip brackure	perior	med? available prior to completion of cause of death?
/ ~	The la		107	es 1 No 1 Yes 2 No
Vital Record	uclan: The lav certificete has irector, pege 2 Be Comp	25. Was case referred to medical examiner?	26. Place of Death (Check only or	
of	hysic lidire	1 AYes 2 10 Inpatient 2 ER/Outpatient 3 DOA	er: Nursing Home 5 Resid	ence 6 □Other (Specify)
n c	ding Phys h. After this funeral d tion: To	27. Manner of Death 28a. Dete of Injury (Month, Day Year) Injury 28b. Time of Injury Work 28c. Injury Work	rat 28d. Describe h	ow injury occurred
Division	tal or Attanding P rs effer death. al Director: After t led in by the funera Certification:	2□ Suiside 6□ Could not be	Yes 2 No Subject	
Ş ∑	effer of Directif	4 Homicide determined building, etc. (Specify)	City or Tow	TID I
	Hospital 24 hours Funeral intely filled	29a. Certifier Physician: To the best of my knowledge, death occurred at the time	9288 H	tickory Mill Road, Salisbury,
•	To the Hospital or Attanding Physician: The is within 24 hours effer death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com	(Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my operand manner stated.	pinion, death occurred et the time, of	date and place, and due to the cause(s)
	within To the comp	29b. Signature and title of ceptifier 29c. License	number 2	29d. Date signed (Month, Day, Year)
		1 Ledel D	30853	2/9/08
		30. Name end address of person who completed cause of death (Item 23a) (Type, Print)		
.,			Division St.Suit	te, Salisbury, Md.21804
	State Registrar	31. Date filed (Month, Day, Year) FEB 1 1 2004 32. Registrar's Signature		
	riegistiai	I LU I LOUI PESSAN DE SON DE S	_	

CAROLINE FRAFTA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Ragistrar Amended#5perFH FCHD, KS 5/24 Contificate of Death Rag. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** MAY 20 2004 10:30 P NELLIE NANCY RUTTER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY **BETHESDA** MANOR CARE NURSING HOME If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 92 MARCH 13 1912 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limite 10a. State 10b. County 28a-f ehow ust be notified at 1 TYes 2 No MD MONTGOMERY BETHESDA Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23e or 20817 USA 6530 DEMOCRACY BLVD. death Funerai 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 12. Was Decedent Eyer in U.S. Armed Forces?

1 Yes 2 No If Yes, Give the Madical Examiner? filed within 72 hours after 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. WHITE Specify: 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) DOMESTIC 9 HOUSEWIFE other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other traumatic event 9DRs. Be PEARL SELENA ASTLIN MARION WILLIAM BEALL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CINDY RUTTER / GRANDCHILD 26607 HANEY AVE., DAMASCUS, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/24/04 MONOCACY CEMETERY BEALLSVILLE, MD * 4 ☐ Donation 5 ☐ Other (Specify) HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, MD 21. Signature of Funeral Service Lidensee 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MYOCARDIAL INFARCTION Immediate Cause (Final disease or condition resulting in death) OHOURS Physician /Medical CARDIONASCHAR DISTASE Due to (or as a consequence of): YEARJ. ATHERY SUEDIOTIC Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner to the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. To Be Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 menths? 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC DISTRUCTURE MUMONINY HOHAT HAI LUIZE, 1 Yes 2 No 3 Probably 4 Unknown CHRONIC RENAL FAILURE DEPLIENTION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 20 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical Other: A Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes -2 ☐ No 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manper of Death Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide hours after within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D53367 Liwarwingar MAY 21, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GATHER BURG, MD: 20878 LOAD, SVITE: 202

DHMH 17 Rev 1/2001

State Registrar

DARNESTOWN

31. Date filed (Month, Day, Year) 32 MAY 2 4 2004

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) May 26^{ay} 2004 12:28AM **Physician** George E. Rawlings ,Sr. /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner 14953 Bassford Road Hughesville Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours D. Wit 0 6 (47th 24 year) 938 9. Birthplace (State or Foreign Marry Land 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 XM 2 ☐ F **Funeral** Yrs 65 217-36-7529 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. Stete 10b. County ortant: If Item 27 is marked other than "natural", or Items 23s or 28s-f show injury or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 📉 No Director **Hughesville** MD Charles 10g. Citizen of What Country? 10e. Street end Number 14953 Bassford Road 20637 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Armed Forces; 1X1Yes 2∐ No If Yes, Give filed within 72 hours efter 1 ☐ Never Married 2 X Merried 1 ☐ Yes 入No Specify Specify: White Baltimore, Maryland 21215-0020 δ 3 ☐ Widowed 4 ☐ Divorced Year or Detes: Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Plumber Plumbing Depertment of Health and Mental Hygie Important: If Item 27 is marked other I any injury or other traumatic event, II! 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Peges 1 end 2 should be nent of Health and Mental Lillian Goldsmith George Thomas Rawlings 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14953 Bassford Rd. Hughesville, MD 20637 Alma Rawlings/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 □ Cremation 3 □ Removal from State Trinity Memorial Gar. 5/29/04 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) M00945 22. Name and Address of Facility P.A. Brinsfield -Echols FUNERAL HOME, P.A. 21. Sign yare of Fundral Service Licensee Box 128 Charlotte Hall, MD. 20622 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical DEPRATATE MEMONIAN Examiner Physician/Medical Examiner attending physician end for use es the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown á 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed TO Yes TON 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 5 esidence 6 □Other (Specify) 1 Yes 200 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28d. Describe how injury occurred

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, funerel director, page 2 should be efter death. filled in by 24 hours

RAWINGS

Medicai Certification: To

27. Menner of Death

29b. Signature and title of certifier

29a. Certifier (Check only one)

2 Accident 6 Could not be determined 3 Suicide 4 Homicide

Date of Injury (Month, Day Year) 5 Pending investigation 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

28c. Injury at Work?

1 Tes 2 No

Location (Street and Number or Rural Route Number, City or Town, State)

Cartifying Phyelclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or mives traition, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29d. Date signed (Month, Day, Year)

who completed cause of

8 2004

31. Dete filed (Month WAY

Registrar

within ?

381	, FOI	partment of Health and Mental Hygertificate of Death	iene _{eg. No.} 2004 8275
Physician /Medical Examiner		4b. City, Town, or Location of Death	
Funeral Director	5. Social Security Number 218-32-9479 6. Sex 1 M 2 F 7. Age (In yrs. last birthda) 34 Yrs. Usual Residence of Decedent		1
BAITIMOYE, Maryiand 21215-0036 parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importsnt: if item 27 is marked other than "nsturel", or items 23a or 28a-1 show any jury or other traumatic svent, the Medicul Ever's at most be notified at once. To Re Completed by Euroral Director	10a. State 10b. County YORK SPRING 10c. Street and Number 6440 SHUTT RD. 11. Marital Status 1 12. Was Decedent Ever in U.S. Amed Forces? 1 1 1 2 2 2 No 1 1 2 2 No 1 2 3 2 No 1 3 3 3 3 3 3 3 3 3	GROVE 10f. Zip Code 1 7 3 6 2 2. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: Sedent's Usual Occupation re kind of work done during most of working NONE 18. Mother's Name (First, Middle, M BETTY JANE 18. Mother's Name (First, Middle, M BETTY JANE O SHUTT RD., SPRING GRO Specific (Name of Paral Route Number or Paral Route Number o	ZEIGLER City or Town, State, Zip Code) DVE, PA. 17362 20c. Location - City or Town, State IANOVER, PA.
ntificate be axecuted ng physician and as the burial-transit Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter United Sequences of cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	54 E. MAIN ST., WESTMIN nter the mode of dying, such as cardiac or respiratory arre	
The law requires that the death certificate sate has been signed by the attending physpage 2 should be detached for use as the Commisted by Physician/Medic	Fall II. Other significant conditions contributing to death out not resulting in the	1 ☐ Ye 24a. Was a autops perform	n 24b. Were autopsy findings available prior to completion of cause of
To the Hospital or Attending Physician: The within 24 hours after death. To the Funarel Diractor: After this certificate completely filled in by the funeral director, page Madrical Cartiffication: To Re CO	25. Was case referred to medical examiner? **Note: The content of the content of	26. Place of Death (Check only on. ent 3 DOA Other 4 Nursing Home 5 Reside of 28c. Injury at Work? 7 PM 1 Yes 2 No street, factory, office 27 Injury at Work? 6 Place of Death (Check only on. 5 Reside 07 Place of Death (Check only on. 5 Place of Death (Check only on. 5 Place of Death (Check only on. 5 Place of Death (Check only on.) 6 Place of Death (Check only on.) 6 Place of Death (Check only on.) 6 Place of Death (Check only on.) 7 Place of Death (Check only on.) 6 Place of Death (Check only on.) 7 Place of Death (Check only on.) 7 Place of Death (Check only on.) 7 Place of Death (Check only on.) 7 Place of Death (Check only on.) 7 Place of Death (Check only on.) 7 Place of Death (Check only on.) 7 Place of Death (Check only on.) 7 Place of Death (Check only on.) 7 Place of Death (Check only on.) 7 Place of Death (Check only on.) 7 Place of Death (Check only on.) 7 Place of Death (Check only on.) 7 Place of Death (Check only on.) 7 Place of Death (Check only on.) 7 Place of Death (Check only on.) 7 Place of Death (Check only on.) 7 Place of Death (Check only on.) 7 Place of Death (Check only on.) 7 Place of Death (Check on.	a) nce XXOther (Specify) At SCENE w injury occurred Decome A PUBLIC STRUCTOR A and Number or Rural Route Number, State) 1 2 7 South Officer Susse(s) and manner as stated.
State Registrar	31. Date filed (Month, Day, Year) MAY 2 1 2004 MAY 2 1 2004	e, Print) 11 Penn Street, Baltimore,	Maryland 21201

DHMH 17 Rev 1/2001

Physicia	an	1. Decedent's Name (First,			77					2. Date of De Month May	Reg. N		3. Time of De 10: 05 A
/Medic	al	Beatrice Eli 4a. Fecility Name (If not ins					4h Cit	v Town o	r Location of Dea			c. County of De	04 10:05
Examine	er	455 N. Jonat	_					gerst				Washing	
neral ector	0	5. Social Security Number 216-22-8649	6. Se:	7. Aq	ge <i>(In yr</i> s. 76	last birthday) Yrs.	If Und Month	er 1 Year s Days	If Under 24 Hr Hours Mir		rth ay, Year	9.8	irthplace (State or Fo Country) MD
-		Usuel Residence of Deced			10c. Cit	y, Town or Lo	cation						10d. Inside City L
fied	tor	MD Wa	shingt	on	На	gersto	wn						1 XYes 2
De not	Funeral Director	10e. Street and Number	1 04				1	2ip Code 1740				itizen of What	Country?
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	erai	455 N. Jonat	nan st	12. Was Decedent	Ever in U.	S. 13. V			ispanic Origin? (Specify Yes or N	US 		nerican Indian,
Important: I reflect to marked utres train i saudat, or rette 200 or 2001 and eny injury or other traumatic event, the Madical Examinational parcellised at once.		1 Never Married 2[3 Widowed 4 Dr		Armed Forces' 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?	l:	f Yes, sp	ecify Cuba 2⊠ No	n, Mexican, Pue Specify:	rto Rican, etc.)		Black, Will Specify:	
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ant, it	e Co	17. Father's Name (First, A				!	110111	Cincinc		ame (First, Middle	, Maide		
lic ev	To B	Maynard Bern	ard He	nderson					Elea	nor (unk) Wa	ashingto	on
auma	-	19a. Informant's Name/Re					-			Rural Route Numb	-		, Zip Code)
thar tr		Benjamin F. 20a. Method of Disposition		/ Son	20h P					Lanham,		20706 Location - City of	or Town State
y or o		1 XBurial 2 Crem 1 Donation 5 0	ation 3 🗆 F	Removal from State		lace of Dispo- emetery, crem			0-1	21/2004		gerstow	
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should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregn in the past 12 months 1 □ Yes 2 □ No 9 □ Unknown	ant	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	Ideath 3□		pregnancy specify)				23d. Date of d Month	lelivery Day Yea
d be detac	by	Part II. Other significant of	onditions co.	ntributing to death I	out not res	utting in the ur	nderlying	cause giv	en in Part I.				to the cause of dea
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lirector, page 2 s	Con									1 Tes	2 N	death? o 1 ☐ Ye	es 2 No
director,	o Be	25. Was case referred to r examiner?	-	Hospital:		50/0		Oth	00	eath (Check only		2 504 (2	
2 0	-	1 ☐ Yes 2 ☐ No 27. Manner of Death		1 ☐ Inpati	ury	28b. Time of		28c. Injun	y at	Home 5 Aes 28d. Describe			ecity)
he funer	atio	2 Accident	Pending investigation	(worth, Da	ay (GEI)	Injury	М		K? Yes 2 □No				
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itely fill	edical	29a. Certifier 1 1 C (Check only 2 M one)	ertifying Phy edical Exami	sician: To the best ner: On the basis of and manner s	of examina	wledge, death tion and/or inv	occurre vestigatio	ed at the tin on, in my o	ne, date and plac pinion, death occ	ce, and due to the curred at the time,	cause(s	s) and manner and place, and di	as stated. ue to the cause(s)
	<u>e</u>	29b. Signature and title of	certifier				2	9c. Licens	e number		29d. D	ate signed (Mo	nth, Dey, Year)
To the Funeral Director: A completely filled in by the fu	Σ	Con Organization and the					- 1	_					

ab	-	-	For State of Maryland	Department Certificate	of Health and of Of Death	Mental Hygiei		18277
			Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic		Susan Louise Rogers			June 3,	2004	a: 25 PM
	Examin		a. Facility Name (If not institution, give street and number)		Town, or Location of Dea	th	4c. County of Death	77
			Lions Manor Nursing Home Social Security Number 6. Sex 7. Age (In yrs. last		mberland	s. 8. Date of Birth	Allegan	<u> </u>
	Funeral Director		233-50-3640 1□M 2⊠F 68	Yrs. Months	Days Hours Mir	8. Date of Birth (Month, Day, Ye June 19,	1935 WV	place (State or Foreign ntry)
			Isual Residence of Decedent					0d. Inside City Limits
	arylan show	<u>-</u>		own or Location berland				1 ☐ Yes 2 XNo
	with the Maryland a or 28a-f show	Director	Oe. Street and Number	10f. Zip (Code	10g.	Citizen of What Cour	ntry?
	with 3a or	i Dir	901 Seton Drive		1502		U.S.A.	•
	death ms 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?		ent of Hispanic Origin? (ify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Americ Black, White,	
9	after or ite	Fur	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes. Give	1 Yes 2		no moan, etc.)		
5.003	ural',	d by	3 ☐ Widowed 4 ☑ Divorced Year or Dates:	6a. Decedent's Usual	LOccupation	16h	Specify: Whi	
Susan 21215-003	in 72 in 72	Completed	(Specify only highest grade completed)	(Give kind of work life. DO NOT use	k done during most of w	orking	. Talle of Dashiosani	
S12	d with giene.	mo	Elementary/Secondary (0-12) College (1-4or 5+) 1 +	nurse	's aide		Medica1	
	al Hy d othe	Be (17. Father's Name <i>(First, Middle, Last)</i> Carl Dean Broome		1	ame (First, Middle, Maid S. A. Runi	·	
S	Menial Me	၉		Oh Mailine Address	(Street and Number or F			Codel
ALYS,	d 2 sh th and 7 Is n traun		19a. Informant's Name/Relationship (Type, Print) Carol Willis/friend	•	mac St., C			
DOLY Dre, Man	Heal Heal tem 2	1 3	20b. Plac	e of Disposition (Nametery, crematory or oti	ne of		Location - City or To	
(X §	Pages ent of nt: If i		1 IXIBurial 2 (Cremation 3 Hemoval from State	omac Mem		/07/04	Keyser,	WV
HO Haltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28e-f shov any injury or other traumatic svent, the Medical Examinat must be multified at once.		21. Signature of Funeral Service Licensee		d Address of Facility Ood Funer	al Home	Tna	
-	825 2		23a. Part1. Enter the disease, or complications that caused the death.				V 26726	Approximate
			shock, or heart failure. List only one cause on each line.	to not enter the mode	e of dying, such as cardi	ac or respiratory arrest,		Interval Between Onset and Death
0	Physician /Medical	ê q	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequer		MYOPATT	14		75 yrs
	Examiner		Sequentially list conditions Due to (or as a consequent of the conditions)	100	DISCHIE			
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ce of):	OT B C T T T		1	
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, ,	be executed ician and burial-transit	i Ex	resulting in death) Last Due to (or as a consequent	ce of):				
09289	ate ohys	dicai	d					
9 X C	± 00 m2	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnant				23d. Date of deliv	өгу
Box	death e atte	icia	23b. Was december pregnant in the past 12 months? 1 Yes 2 No 9 Virknown				Month	Day Year
	that the de ed by the detached	Phys	9 L Unknown		and the second	22a Did tabaa	co use contribute to t	he course of death?
s,	res th signed be de		Part II. Other significant conditions contributing to death but not resulti ア ハイクトアテン ハイント 「アル」	ng in the underlying ca ろ てんさ	=		2 □ No 3 □ Prol	
oro	iw requires that s been signed b should be deta	eted	Purmontar Hypertrension	71,00	,,,,,	24a. Was an		ppsy findings available
ec Sec	ne law has t	Completed by				autopsy performes	prior to co	mpletion of cause of
<u></u>	ilcian: The la certificate has rector, page 2	e Co	CHRONIC OBSMULTIUF Phym 25. Was case referred to medical	10.000 7 01	26 Place of D	1 ☐ Yes 2 X eath (Check only one)	No 1 ☐ Yes	2.X No
<u> </u>	ysicie is cert direct	O B	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ EF	/Outpatient 3 DO	Other	Home 5 Residence	e 6 Other (Specia	5)
o c	ng Ph fter th meral	Di: T	27. Manner of Death 28a. Date of Injury 28a. Date of Month, Day Year) 28a. Date of Injury (Month, Day Year)		8c. Injury at Work?	28d. Describe how i	njury occurred	
<u></u>	tendi leath. tor: A the fu	cati	2 Accident investigation	M form about fortune	1 ☐ Yes 2 ☐ No	28f Location (Stree	t and Number or Run	al Route Number
Division of Vital Records.	or At after of Direct in by	Certification:	4 Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	i, iaim, street, iactory,	r, onice	City or Town, S		ar riodio riambor,
	To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle 2 Madical Examinar: On the basis of examination and manner stated.	dge, death occurred a	at the time, date and pla , in my opinion, death oc	ce, and due to the caus curred at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
_	o the ithin 2 o the omplei	Med	one) and manner stated. 29b. Signature and title of certifier	29c	: License number	29d.	Pate signed (Month,	Day, Year)
	C > F 0) Jan C. Senoll	#	FD4205	4 13	une 4, 3	4004
	2		30. Name and address of person who completed cause of death (Item 2	3a) (Type, Print)	No.	ahaili	1	DIENA
	0,		31. Date filed Month, Day, Year) 32. Registrant Signatur	1'd Detty		umberla	na, MD	41309
	St: Regist	ate rar	JUN 0 8 2004		W.			

			1 - For State Registrar	State of Ma	ryland / De	epartmer Certificat	t of Hea e of De	alth and Meath	lental Hy	giene Reg. No.	2004	18278
	4		1. Decedent's Name (First, Middle, La	ast)			· · · · · ·		2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		William Clyde F	Reinke					May	27,	2004	12:00P ^M
	Examin		4a. Facility Name (If not institution, gir				_	cation of Death			County of Death	
			10232 Scaggsville			Lauı		Under 24 Hrs.	0.0(0)		vard	-land (Charles on Francisco
	Funeral		, , , , , , , , , , , , , , , , , , , ,	Sex 7. Age 1√∑ M 2□ F	(In yrs. last birth	Months		Hours Min.	8. Date of Bill	ay, Year)	Cou	
r.	Director		403 00 7334	X	58 Yr	3.			July 7	, 194	45 Tex	as
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	Aaryl f sho	ō	Maryland Howard		Laurel							1 □Yes 2X No
	the 28a-	ect	10e. Street and Number		Dadrer	10f. Zi	Code			10g. Citiz	zen of What Cou	ntry?
	ath with the Marylar s 23a or 28a-f show wat be notified at	ā	10232 Scaggsville	e Road		207	723			USA		
	after death with the Maryland or Items 23a or 28a-1 show mirer must be notified at	Funeral Director	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Dece	dent of Hispa	anic Origin? (Sp Mexican, Puerto	ecify Yes or No	o- 1	14. Race - Ameri Black, White	
	or Ite	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give	0	1 Yes		Specify:	ritouri, oto.)		Specify:	oto.
2-003e	within 72 hours after ene. than "natural", or Ite he Medical Estimine	1 by	3 Widowed 4 Divorced	Year or Dates:			2,110				Whi	
2	72 honatu	Completed	15. Decedent's E (Specify only highest g	Education rade completed)	1	Decedent's Usu Give kind of wi	ork done durir	n ng most of work	ing	16b. Kir	nd of Business/Ir	ndustry
7	nthin ne. hen	mp	Elementary/Secondary (0-12)	College (1-4or 5+ 5+	·)	ite. DO NOT∶ ociate	•	+ 0 r		Info	rmotion	Technology
7	at Hygier other th		17. Father's Name (First, Middle, Las		ASS	ociate		. Mother's Nami	e (First, Middle			. recimology
yland	be fi	Be	Theodore Frederic					ena Brov			•	
	should and Men marks umatic	10	19a. Informant's Name/Relationship		19h I	Mailing Addres				er. City or	r Town, State, Zi	p Code)
Ma	d 2 sl th and 7 is r										yland 2	
	1 and Health em 27		Vicky H. Reinke/ 20a. Method of Disposition	wire	20b. Place of I	Disposition /Na	me of		Date 28,	20c. Lo	cation - City or T	own, State
و	Pages nent of ant: If it ary or o		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		W. Arun	, crematory`or de1 Cre		1 -	004	0der	nton, Ma	rvland
Baltimore,			21. Signature of Funeral Service Lic								P.O. Bo	
œ M	permit. Depent Import any inj once		Bow On & Ho		0/251	Going	Home (Crematic Heckroti	n Serv	ice . Cla	P.O. BO	x 784 e, MD 21029
	E		23a. Part1. Enter the disease, or co	molications that caused	the death. Do no							Approximate Interval Between
	Bi states		shock, or heart failure. List onli Immediate Cause (Final	ly one cause on each lin	θ.	1						Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Fulmon	HK consequence of	deme						_1 CI H Y
5	Examiner			Glioble	SOMA	Mul-	+.fre	mE				14 months
	g _A	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of	9-						
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o,	te be executed ysicien and te burial-transit		resulting in death) Last	Due to (or as a	a consequence of	f):						
3760,		cai		d								
89	iffic g p	Physician/Med	IF FEMALE:									
Box	ith cert tendin or use	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth	2 Fetal death	3 □Ectopic				1	23d. Date of delin Month	very Day Year
	e dea the at	sici	1 Yes 2 No	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 Other (s	specify)					
0	that the de led by the a detached t	P.	Part II. Other significant conditions	contributing to death by	it not resulting in	the underlying	cause given i	in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
ŝ	ires tha signed d be del	þ	Faith, Other signmount outdates	00111100111191000001			3		1 🗆	Yes 2	XNo 3 □ Pro	bably 4 Unknown
50	w requir been si should	Completed							24a. Wa		24h Ware aut	oney findings available
ec	e law has b	age 1							auto	s an opsy formed?	prior to co	opsy findings available ompletion of cause of
<u></u>		Ö							1 ☐ Yes	2 X No	1 Tes	2 No
Vital Records,	Physician: The this certificate hiral director, page	Be	25. Was case referred to medical examiner?	Hospital:			Other	6. Place of Deal			• Co	w)
o	Physical this all directions	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatie			NA	4 Nutsing H	28d. Describe		6 □Other (Spec y occurred	ny)
5	Jing After fune	lo E	1 Natural 5 ☐ Pending	(Month, Day	Year) In	jury M	28c. Injury at Work? 1 Yes	s 2 No				
Division	Attending r death. ector: After by the fune	Certification:	3 Suicide 6 Could not	t be 28e. Place of Inju	ury - At home, far				28f. Location	(Street an	d Number or Ru	ral Route Number,
<u>></u>	or A after Direct	ertit	4 Homicide determine	building, etc	. (Specify)		,,		City or To	own, State)	
_	• Hospitel or Attend 24 hours after death • Funerel Director: etely filled in by the		29a. Certifier 1♥ Certifying	Physician: To the best of	of my knowledge,	, death occurre	d at the time,	, date and place,	and due to the	e cause(s)	and manner as	stated.
	24 h 24 h e Fur	edical	(Check only 2 Madical Ex	caminer: On the basis of and manner sta	examination and	Vor investigation	n, in my opin	ion, death occui	red at the time	, date and	I place, and due	to the cause(s)
	To the Hospitel or Attenwithin 24 hours after deall To the Funerel Director: completely filled in by the	Me	29b. Signature and title of certifier			2	9c. License n	number		29d. Dat	te signed (Month	, Day, Year)
			1 Call	re MO			b 22	1755		May	28, 200	4
2	102		30. Name and address of person wh	no completed cause of d	eath (Item 23a) (Type, Print)		#2	160	y	1 1	
1	, •		Christine	DELIMA	M.D.	7350	VAN	BUSEL	, Kd	Laur	EL, MD	20707
		ate	31. Date filed (Month, Day, Year)	2004 32. Registra	ar's Signature	1						
	Regist	trar	mm1 4 0	LUU4 198	as to	Lineals	11					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryla		icate of			APR	ΩL	10	070		
	Physician	1. Decedent's Name (First, Middle, Las					2. Dete of Deat Month	h	(ear	. Time of D	eath/		
	/Medical	MARGA 4a Fecility Name (If not institution, give	ARET ELIZABET	TH SNYDER		4b. City, Town, or L	May	20, 200		:31	PM		
j	Examiner	St. Joseph's Medic				Towson		Ralt-	imore				
14	Funeral Director	377-20-8038	9X 7. Age (In y		Under 1 Year onths Days	Hours Min.	8. Date of Birth (Month, Day, Apr. 6,	1922 1	9. Birthplace Country) Maryla	(State or I	Foreign		
	erylend ehow det	Usuel Residence of Decedent 10a. State 10b. County	10c.	City, Town or Location	on				10d. I	Inside City	Limits		
	the Meryle 28e-1 eho notified at	Maryland Baltimon	re T:	imonium					1	1∐XYes 2	2 □ No		
	with the or 28 Direction of the Ora28 Direction of the Ora28 Directi	10e. Street end Number 215 Belmont Foresi	r Court Unit		Of. Zip Code 2.1 (093	10	og. Citizen of Wh	et Country?				
20	72 hours effer deeth with the Meryland neturel; or Heme 23e or 28e-f show life! Examiner must be notified at sted by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	n U,S. 13. Was		lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Decify Yes or No- Decify Yes or No-	14. Race	American Ir White, etc.				
9-0	2 hour	15. Decedent's Ed	ucation	16a. Decedent	s Usual Occup	eation	16b Kind of Business/Industry						
21215-0020	within and the man	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	1	NOT use retired e Supe	during most of world) rvisor							
od 2	be filed tel Hygid d other event, to	17. Father's Name (First, Middle, Last)			-	18. Mother's Nam	ne (First, Middle, N	-					
ylaı	Menta Menta Menta Merked Merked	Russell Lansdale					Allnutt						
Maryland	s 1 end 2 should be filed f Health end Mentel Hyg tem 27 is marked othe other traumatic event, To Be C	19a. Informant's Name/Reletionship (7) William R. Snyder	ype, <i>Print)</i> (Brother)			and Number or Ru orest Cou		-			21093		
Baltimore,	e = 5 e	20a. Method of Disposition 14 Burial 2 Cremation 3 4 Donation 5 Other (Specify		b. Place of Disposition cemetery, cremato aytonsvill				evtonsv	_		land		
Balti	permit. Pege Depertment of Important: If any injury or office.	21. Signature of Funeral Service Licens		RÖBE	me and Addre	ss of Facility & DAILEY & MARKET S	SON FUNE	RAL HOMI	ES, P.	Α.			
		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only of	one cause on each line.						App	oroximate erval Betwe	en :		
)	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a	neuw	n'e				Ons	set and De	ath		
	_		Due to	o (or es a consequen	ce of):				1				
30,	ficete be executed in physician and strength in the puriel-transit as the buriel-transit edical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events require in death). Let	Due to	Color (or as e consequence	ce of):	CRR.							
x 68760,	\$ 0.0 E	that initiated events resulting in death) Last	Due to	Coton (or as e consequence RBSP1	201): RAFOK	y FAIL	URR 20	CHF	1				
Вох	deeth cert e ettendin rd for use												
P.O.		Part II. Other significant conditions co	entributing to death but not	resulting in the under	lying cause giv	en in Part I.		bacco use contr is 2□No 3	Probably		T.75.30.34		
Records,	been si should						24a. Wes er perform	autopsy ned?	24b. Were at availabl complet of death	le prior to ition of cau			
2	The lew sete has pege 2.						1 🗆 Ye	£ 1000	1 ☐ Ye:	s 2 N	lo		
Vital		25. Was case referred to medical examiner?					th (Check only one	9)					
of \	this did	1 ☐ Yes 2 ☑ No 27. Manger of Deeth	Hospital: 1 Inpatient 2	2 ER/Outpatient 3	DOA Oth	4 LI Nursing no	ome 5 Reside						
Division	After fune	Naturel 5 Pending (Month, Day Year	r) Injury	28c. Injur Wor VI 1□	k? Yes 2□No								
Divi	To the Hospital or Attending is within 24 hours efter death. To the Funerel Director: After completely filled in by the funerel Medical Certification	4 Homicide determined	28e. Place of tnjury - A building, etc. (Spe	At home, farm, street, a ecify)	factory, office		28f. Location (Str City or Town	eet and Number , State)	or Rural Rou	ite Numbe	И,		
	he Hospital in 24 hours he Funerel I pletely filled edical Co	29a. Certifier Certifying Phy (Check only one)	rsicien: To the best of my liner: On the basis of exam and manner steted.	knowledge, death occ nination end/or investi	curred at the ting gation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and mann te and place, and	er as stated d due to the	cause(s)			
	To the vithin To the comp	29b. Signature and title of certifier	MO			8459		Od. Date signed (- 04	16.			
	3	30. Name and eddress of person who con SYRD ZAID!	ompleted cause of death (1	ttem 23a) (Type, Print FURNATO gnature	2 BR	ANCH A	20.46	NBUR	NIR	M06	0		
	State Begistrar	31. Dete filed (Month, Day, Year)	32. Registrar's Si	gnature	An	and 1							

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 24, 2004 May 03:30 AM Siciliano Justine /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Malcolm Grow Medical Center Camp Springs If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 M 72 213 28 0043 1931 Maryland Sept 26. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County or 28e-f show rthan "natural", or items 23a or 28e-f shov the Medical Examinar must be notified at 1 ☐ Yes 2 📉 💥 Fort Washington Funeral Director Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20744 United States 7613 Lanham Lane 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status illed within 72 hours after 1 Never Married XX Married 1 ☐ Yes 2 ☐ You If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 🏌 No White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any Injury or other traumatic event, the Mauli page. College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Hildegard Alice Krhounek John M. Sibol 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Paul R. Siciliano (Husband) 7613 Lanham Lane, Fort Washington, Maryland 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XX remation 3 Removal from State
4 Donation 5 Other (Specify) Lee Crematory May 24, 2004 Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, Maryland 20735 MØ1190 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumonia Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or tripley that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed and Due to (or as a consequence of): physician ar P.O. Box 68760. Physician/Medical as the t IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2/1/No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 2. No 3 □ Probably 4 □Unknown 1 ☐ Yes Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2**X**XIO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes ZENo 1 X Inpatient 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? i or Attending Patter death.

Director: After t Certification: 5 Pending XXNatural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier MO7 24, 2004 MO-071370-C A. Norta 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David A. Norton, MD Malcolm Grow Medical Center AAFB Camp Springs, Md. 31. Date filed (Month Pary) 32. Redistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Year **Physician** Muriel E. Smith 15 0715 May 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll 225 Frock Drive Westminster Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 M 2 F Vrs NJ Director 86 1 1918 158-07-5470 the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral, or items 23a or 28a-f ehow Exercises must be natified at 1 Yes 2 No MD Carrol1 Westminster Direct 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number #230 21157 225 Frock Drive USA death Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Never Married 2 Harried 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White ⋧ 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry Compi Elementary/Secondary (0-12) College (1-4or 5+) 12 Pediatric Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Health and Mental is marked Edmund David Slater Mary E. Scarth ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) if itam 27 i 225 Frock Drive #230 Westminster, MD Grayson Smith/husband 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5/1972004 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. `4 □Donation 5 如Other (Specify) Mausoleum Evergreen Memorial Gardens Finksburg, MD 22. Name and Address of Facility
Pritts Funeral Home and Chapel, P.A. 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and characteristics. Most a standard contractions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and characteristics. 21157 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BRAIN cezebroucaculan Accident **Physician** en 9 Biverica /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) the attending physician a hed for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 4,94,99,90 m 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has 1 ☐ Yes 2 XNo Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ၉ this 28a. Date of Injury (Month, Day Year) in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation M 2 Accident after death Diractor: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} \) To the Hospital within 24 hours a To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3166 WSZ 3C4 0511712004 Y WIND 21157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEWER AVENUE WESTIMMSTER MARRIAN (ALVIN III HOMAS K. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Genera & Spark MAY 18 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Irvin Sims 04-03186 RPD

31	.00		For State Registrar	State of Mar		artment of Health ar tificate of Death		200	18282
			Registrar 1. Decedent's Name (First, Middle, Last)		- 061	uncate of Death	2. Date of Deat		3. Time of Death
	Physici		Irvin Dallas Sim				May 11,	, 2004 Year	11:11A M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or Location of	Death	4c. County of Dee	eth
			Carroll Hospital (Westminster		Carroll	
	Funeral Director		5. Social Security Number 213–46–4087 5. Security Number 213–46–4087	7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year If Under 24 Months Days Hours	Min. 8. Date of Birth (Month, Day May 10	1949 9. Bi	rthplace (State or Foreign country) MD
	and		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Lo	cation			10d. Inside City Limits
	Maryli f sho	Į.	MD Carro	11	Ne	w Windsor			1 □Yes 2 🙀 No
	h the	Director	10e. Street and Number			10f. Zip Code	1	0g. Citizen of What C	ountry?
	th wit		1155 Western Cha	pel Road		21776		USA	
	tems	Funeral	T. Maria States	12. Was Decedent Ev Armed Forces?	er in U.S. 13. 1	Nas Decedent of Hispanic Origi f Yes, specify Cuban, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Am Black, Whi	
36	be tiled within 72 hours after death with the Maryland tial Hygiene. So ther than "naturel", or thems 23e or 28e-f show event, the Medical Examinar must be notified at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No Specify:		Specify: F	Black
21215-0036	2 hou ature	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occupation	of working	16b. Kind of Business	s/Industry
215	within 7 ene. than "n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done during most on NOT use retired)	or working	Chic's Co	oncrete
	e filed within al Hygiene. I other than ' vent, the Me	Con	12		0	wner/Operator	s Name (First, Middle, M	Contracto	rs
Maryland	I be fill htal H ed otl	Be	17. Father's Name (First, Middle, Last) Walter Sims				more Wilson	•	
ž	s 1 and 2 should be f Health and Mental item 27 is marked o	은	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailir	ng Address (Street and Number			Zip Code)
	nd 2 ulth a 27 is r trau		Deborah Sims/wife		1155	Western Chape	l Road New	Windsor,	MD 21776
Jre,	s 1 and 2 of Health item 27 other tra		20a. Method of Disposition		20b. Place of Dispo	sition (Name of natory or other place)	5/15/2004	20c. Location - City o	r Town, State
Ē	Pages nent of I ant: If its ury or o		1 Burial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)	demoval from State		Chapel Cemeter	Y		ndsor, MD
Baltimore,	permit. Pages Department of H Important: If ite any injury or of		21. Signature of Foneral Service Ocens	11	22	Name and Address of Facility Pritts Funeral	Home and C	hapel, P.A	A. 21157
	- 9,		23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused the			/	/ \	Approximate Interval Between
	Physician	02 3	Immediate Cause (Final disease or condition	171	anosele	white Coslid	Veterlan	Discas	Onset and Death
	/Medical Examiner		resulting in death)	Due o (or as a	consequence of):		-Tellifor - Tel		
	Examiner :	_	Sequentially list conditions, if any, leading to immediate	b. Due to for as a	consequence of).				
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	20010101000	50110041100 01/.				
Ć	execunation and ial-tra	Еха	that initiated events resulting in death) Last	Due to (or as a	consequence of):				
68760,	icate be executed physician and s the burial-transit	edlcal		d					
-	ntifica ing ph e as th		IF FEMALE:		This experience				
Вох	The law requires that the death certificate has been signed by the attending for age 2 should be detached for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2	Fetal death 3	Ectopic pregnancy		23d. Date of de Month	elivery Day Year
0	at the deby by the a stached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tii 9□ Unknown	ne or death 5L	Other (specify)			
4	that the by detail		Part II. Other significant conditions co	ntributing to death but	not resulting in the u	nderlying cause given in Part I.	23e. Did tob	pacco use contribute t	o the cause of death?
Records,	w requires been signe should be	ed by			···		1 □ Ye	es 2□No 3	robably 4 Unknown
000	aw recast bee	ompleted					24a. Was a		utopsy findings available completion of cause of
Ä	The lavate has	Com					perform	ned? death?	•
Vital	iclan: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	1			of Death (Check only on	θ)	
of \	this al di	. To	1X Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient	2 XER/Outpatier 28b. Time o		sing Home 5 Reside	nce 6 Other (Speniew injury occurred	ecify)
	ding h. After fune	tlon	1 Pending 5 ☐ Pending	(Month, Day	(ear) Injury	Work? M 1 ☐ Yes 2 ☐ N		William Cooding	
Division	or Attending after death. Director: Afte in by the fune	ifica	3 Suicide 6 Could not be		/- At home, farm, str	eet, factory, office	28f. Location (St. City or Town	reet and Number or R	Tural Route Number,
Ö	tal or A s after at Direct	Certification:	4 Homicide	building, etc.	(Зреспу)		City of Town	, Siale)	
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in b	edical (xamination and/or in	n occurred at the time, date and vestigation, in my opinion, death			
	Fo the vithin Fo the comple	Med	29b. Signature and title of certifier	^		29c. License number	29	9d. Date signed (Mon	th, Day, Year)
			Y & Cartes	(M)		O.C.M.E.		May 12, 20	004
	MIL		30. Name and address of person who c	ompleted cause of dea	ith (Item 23a) (Type,	Print) 11 Penn Street	, Baltimore	e, Maryland	1 21201
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registar 2004	s Signature				
	Regist	rar	MAI 17	ZUU4 CO	m &	Break 1			

		í	1 - State of Mary Registrer		artment of H			iene 19. No. 200	14 1828:
	Physici /Medic		1. Decedent's Name (First, Middle, Last) James Elmo Steger		,		2. Date of Death Month May 15	Day Yea 2004	4:12 a ^M
	Examin		4a. Facility Name (If not institution, give street and number) Long View Nursing Home			r Location of Death nester		4c. County of De	roll
	Funeral Director		5. Social Security Number 6. Sex 7. Age (Ir	yrs. last birthday) 32 Yrs.	If Under 1 Year Months Days	Il Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sep 13,	Year) 9. 8 1911 M	irthplace (State or Foreign Country) aryland
	yland how		Usual Residence of Decedent 10a. State 10b. County 10	c. City, Town or Lo					10d. Inside City Limits
	with the Ma a or 28a-f s Les notifies	Funeral Director	Maryland Carroll 10e. Street and Number 3248 Maiden Lane		10f. Zip Code	Mancheste 21102		Og. Citizen of What (-
920	iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other treumatic event, it a Modical Examinational to redifficial at	þ	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ☑ No II Yes, Give Year or Dates:		Was Decedent of H II Yes, specify Cuba 1 ☐ Yes 2√2 No	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race · Ar Black, Wi Specify:	nerican Indian, nile, etc. white
21215-0036	hin 72 ho e. nn "natur M. dical	Completed	15. Deceden's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of word d)	king	16b. Kind of Busines	sundustry ruction
	2 should be filed withing and Mental Hygiene. Is marked other than sumatic event. Its M	Be	5 17. Father's Name (First, Middle, Last) Charles F. Steger	.,	Home Buil	18. Mother's Nam	ne (First, Middle, M	Maiden Sumame)	ruction
Maryland	and 2 should salth and Men n 27 Is marke ier treumatic	T	19a. Informant's Name/Relationship (Type, Print) Sterling R. Leppo, stepson		_	and Number or Ru	ral Route Number,	City or Town, State urg, MD 2	
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr ance.		20a. Method of Disposition 1 Disposition 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		osition (Name of matory or other place neran Cem		Date 2	Manches	
Balti	permit. Pag Department Importent: b any injury o		21. Signature of Fineral Service Licensee MOO	723° 2	2. Name and Addre			uneral Ho ead, MD 2	
+	Physician /Medical Examiner	ner	23a. Part 1. Enter the disease, or complications that caused the shock, or heart lailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to mineralise cause. Enter Underlying Cause (Disease or injury)	-	ter the mode of dyin	ng, such as cardiac	or respiratory arre	ost,	Approximate Interval Between Onset and Beath 2 CM
3760,	ate be executed hysician and he burial-transit	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a co	onsequence of):	1 ng				gay
O. Box 68	The law requires that the death certificate be executed ate been signed by the attending physician and bage 2 should be detached for use as the buriat-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown]Fetal déath 3	□Ectopic pregnancy	/		23d. Date of o	lelivery Day Year
<u>α</u>	uires that the signed by to detach	d by Ph	Part II. Other significant conditions contributing to death bull n	ol resulting in the u	underlying cause giv	en in Part I.	23e. Did tob	_ مد	to the cause of death? Probably 4 □Unknown
Records,		Complete					24a. Was ar autops perform 1 Yes 2	y prior t	
Vital	Physicien: The lav this certificate has ral director, page 2:	To Be (25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatie	nt 3□ DOA Oth		th (Check only one	e) nce 6 □Olher (Sµ	pecify)
Division of	는 근 등		27. Manner of Death 1 Natural 5 Pending (Month, Day Ye 2) Accident investigation	28b. Time o	of 28c. Injur Wor		28d. Describe ho		
Divis	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: Atter completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (3	- At home, larm, si Specify)	reet, factory, office		281. Location (Str City or Town		Rural Route Number,
	the Hospital or hin 24 hours afte the Funerel Dir npletely filled in I	Medicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of m 2 Medical Examiner: On the basis of examiner stated	amination and/or in	th occurred at the time the time the stigation, in my convertigation, in my convertigation.	me, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and manner ate and place, and d	as stated. ue to the cause(s)
	M2r Some	Z	29b. Signature and title of certifier Muldlette	7	29c. Licens	5443	29	9d. Date signed (Mo	nth, Day, Year)
*	V	ate	30. Name and address of person who completed cause of death John W. D.; Add Leften 31. Date liled (Month, Day, Year) 32. Registrar's	4881	Poole K	Poal, V	Vestmi	ister, M	12157
9	Regist	rar	MAY 1 8 2004	e #,	Sperke				
יוט	IMH 17 Rev 1/2	_UU I		ORIGIN	IAL				

			For State Registrar AMEND TTEM	State of Ma ITEM #23b	-	•					Reg. No.	2001	1 10 10
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last) IRVIN DAVID SMOOT 4a. Facility Name (If not institution, give seconds)					n, or Location		2. Date of De Month MAY 1	7, 20	Year 004 County of Deat	3. Time of Death 8:00 PM
	Funeral Director	er	2098 FRIENDSVILLE 5. Social Security Number 6. Sex	ROAD		last birthday) Yrs.	FRIE If Under 1 Ye Months Da			8. Date of Bir (Month, Da NOV • 1	th ly, Year)	RRETT 9. Bird Co	hplace (State or Foreign buntry) RYLAND
	0	ctor	Usual Residence of Decedent		10c. Cit	y, Town or Lo	cation DSVILLE						10d. Inside City Limits 1 ☐ Yes 2 X No
2	23e or 28	al Director	10e. Street and Number 2098 FRIENDSVILLE	ROAD			10f. Zip Coo 2153				10g. Citiz	en of What Co	ountry?
020	/z nouts after death with the maryland natural', or Items 23e or 28e-f show dical Examenal must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 ☐ If Yes, Give Year or Dates:			Was Decedent f Yes, specify (1 ☐ Yes 2🎇	Cuban, Mexica	n, Puerto	ecify Yes or No Rican, etc.)		4. Race - Ame Black, Whit Specify: WF	
7	within ene. then "	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or	5+)	(Give	dent's Usual Ockind of work do DO NOT use re ERER	one during mos	st of worki	ng		d of Business	
ylarıd	inould be tiled of Mental Hygin marked other matic event, I	To Be C	17. Father's Name (First, Middle, Last) ORVAL		юот	Tab Mails	ng Address (Str	NE'	TTIE	(First, Middle	M	EEKINS	Zin Code)
	es 1 and 2 s of Health ar fitem 27 ls r other treu		19a. Informant's Name/Relationship (Ty. GARY SMOOT - SON 20a. Method of Disposition 1 □ Burial 2 ☼ Cremation 3 □ R		٠ ١	P.O.	BOX 41 sition (Name of natory or other	6 Mc	HENRY	MARY]	LAND 20c. Loc	21541 eation - City or	Town, State
	permit. Pag Department Important: I any injury o		'4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service License	- Cons	OM MOO 1	22	EMATORY Name and Acute of the Control of the Contro	ddress of Facil	-	P.O.	BOX		
ı	Physician /Medical		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each li	ne. REN	AL FAI		dying, such as	s cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death 1 MONTH
,00,	e executed ian and urial-transit	Ical Examiner		Due to (or as Due to (or as Due to (or as	CLER a conseq	OTIC C.	ARDIOVA	SCULAR	DISE	ASE			
.C. DOA 98	at the death certificate b by the attending physic tached for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fete	death 3	Ectopic pregna				2:	3d. Date of del Month	ivery Day Year
necolus, r.	The law requires that the ate has been signed by the page 2 should be detached.	b	Part II. Other significant conditions con	_		-		e given in Part	l.		Yes 2□	No 3∏Pr	tonsy findings available
ישר ופו		e Completed	25. Was case referred to medical				-	26 Plac	e of Death	auto	psy ormed? 2X No	prior to death? 1 ☐ Yes	completion of cause of
	ding Phys n. After this funeral di	To B	avaminar?	dospital: 1 □ Inpati 28a. Date of Inju (Month, Da		ER/Outpatier 28b. Time o Injury	28c. l	Othors	ursing Ho	me 5 □ Resi 28d. Describe	dence 6		cify)
DIVISION	To the Hospitel or Attens within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	tc. (Specia	(y) 				City or To	wn, State)		ural Route Number,
	To the Hospitel or Al within 24 hours after of To the Funeral Direc completely filled in by	edical	29a. Certifier (Check only one)	sicien: To the best ner: On the basis of and manner st	of examina	wledge, deat tion and/or in	vestigation, in r	my opinion, de	nd place, ath occurr	and due to the ed at the time,	date and	place, and due	to the cause(s)
,	with To Corr	×	29b. Signerture and title of pertifier		4	000	D2	3979				18, 200	
			31. Date filed (Month, Day, Year)	LSKI, M.D		ahuro	311 N.	FOURTH	ST.	OAKLAN	ND, M	D 21550)
	Sta Regista		MAY 1 9 2	DOA Blo.	last South	# A	house						

		1 - For State Registrar	State of Maryland	d / Depa		ealth and M	ental Hygie	•	18285
		1. Decedent's Name (First, Middle, Last)					2. Date of Death	_	3. Time of Death
and the second s	ysician Medical	Nellie Mae Shuman					Month	20 200	4 9:25PM
L.	aminer	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death	//	4c. County of Dea	
		Coffman Nursing	Home		Hagers	town	•	Washin	gton
Fun	eral	Social Security Number 6. Sex		* .	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Bir	thplace (State or Foreign
Dire	ctor	214-09-3416	M 2□ X F	93 Yrs.		<u> </u>	March 11	,1911 Ma	aryland
and	222	Usual Residence of Decedent 10a. State 10b. County	10c, City	, Town or Loc	eation				10d. Inside City Limits
Maryl f sho	or or	Maryland Washing		ınkstov					1 X Yes 2 □ No
the	Tecl B	10e. Street and Number	ton re	IIIKSLU	10f. Zip Code		100	. Citizen of What Co	ountry?
with 3a or	4 0	109 South High St	reet		21734			USA	Tankiy i
death with the Maryland ms 23a or 28e-f show	naminer must be natified by Funeral Director		12. Was Decedent Ever in U.S	S. 13. V		spanic Origin? (Spec n, Mexican, Puerto F	cify Yes or No-	14. Race - Ame	arican Indian,
or its	를 교	1 ☐ Never Married 2 ፟ Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give				tican, etc.)	Black, Whit	e, etc.
5-0036 72 hours at	Exa d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	'	☐ Yes 2 X No	Specify:		Specify: Wh	ilte
5-6	t. the Medical E Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Deced (Give I	ent's Usual Occupa	ation furing most of workin)	g 16	b. Kind of Business	Industry
127	Ma Idu	Elementary/Secondary (0-12)	College (1-4or 5+)	_)			
4 21	Co	11. Tather's Name (First, Middle, Last)		Seam	stress	18. Mother's Name			nufacturer
and d be file antal Hy	evan Be	Clifford Nathanie	1 Rouman						
ILY III	matic To	19a. Informant's Name/Relationship (Type		19h Mailin	Address (Street a	Margie A		Over City or Town, State, 2	Tin Code l
Baltimore, Maryland 21215-0036 Popartimen of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-1 show	trau	Jacqueline Grove/				od Drive,			
r Fe	othe	20a. Method of Disposition	20b. Pla	ace of Dispos	ition (Name of atory or other place	DI DI IVE,		c. Location - City or	21740 Town, State
mo mo Pages	7 0	1 XBurial 2 ☐ Cremation 3 ☐ Re 1 4 ☐ Donation 5 ☐ Other (Specify)	anioval nomi State		atory or other place en Cemete	1	2004 Ha	coratorn	Maryland
altimo	in ei	21. Signature of Funeral Service License			Name and Addres			Funeral (
O W FOR	any ir	> Slepha M. So	in			1100			Md. 21742
2		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	catous that caused the death.	. Do not ente	r the mode of dying	, such as cardiac or	respiratory arrest	,	Approximate Interval Between Onset and Death
Physic	ian	Immediate Cause (Final disease or condition	Atherosder	oTic	Day	alsenel	_	7	Onset and Death
/Med Exami	_	resulting in death)	Due to or as a consequ	nce of)	0 11 +	1			
Exami		Sequentially list conditions, b	atmal	Jes	snelde	w		71	Tears
pe	rial-transit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a consequence	encerof):				- (/	Pour S
Physical Description Box 68760, eath certificate be executed attending physician and	xan	that initiated events cresulting in death) Last	Due to (or as a conseque	ence of):				/ /	few)
8760, ate be ex hysician	cal E	l.							
687 687 ifficate	edic	_ d	-						
OX OX	e esn	IF FEMALE: 23b. Was decedent pregnant 23	Bc. If yes, outcome of pregnan	icy				23d. Date of deli	verv
Geath death	d for	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fetal (4 Pregnant at time of de		Ectopic pregnancy Other (specify)			Month	Day Year
O. o.	etached for use as the Physician/Med	9 Unknown	9□ Unknown						
ds, F ds, F uires tha	be detached by Physic	Part II. Other significant conditions con	tributing to death but not resul	ting in the un	derlying cause give	n in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ecords, law requires as been sign		Mynitage				9	1 🗆 Yes	2 ☐No 3 ☐ Pro	obably 4 Unknown
Recc Recc	2 should	Cougesti	e dear	fo	alur		24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
The The	page 2 should	V		\bigvee			performed	d? death?	2 No
of Vital F Physician: Th	Be (25. Was case referred to medical examiner?				26. Place of Death (Check only one)		
of \	To dir	1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ E		the same of the sa	4 (Shaising nonit		e 6 Other (Spec	eity)
on con ding F	lon	1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	?	d. Describe how	injury occurred	
ision (tranding death.	y the	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hon	ne farm etre		es 2 □No	tf Location (Stree	at and Number or Ru	ral Pauta Number
Division Att	ed in by the funera Certification;	4 Homicide determined	building, etc. (Specify)	10, 14111, 3116	st, ractory, office		City or Town, S	State)	al noute Number,
spite hours	a C	29a. Certifier 1 4 Certifying Phys	ician: To the best of my know	rledge, death	occurred at the time	e, date and place, an	d due to the caus	e(s) and manner as	stated.
Division To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Afte	completely filled in by the funeral director, page Medical Certification; To Be Com	(Check only 2 Medical Examin	er: On the basis of examination and manner stated.	on and/or inve	stigation, in my opi	inion, death occurred	at the time, date	and place, and due	to the cause(s)
To t To t	E CO	29b. Signature and title of certifier	. /		29c. License	number	29d.	Date signed (Month	, Day, Year)
~		STIMELY Chi	my my		1)360	55	Ma	431;2	004
· H.		30. Name and address of person who cor	inpleted cause of death (Item :	23a) (Type, P	rintly 3-3	HAn.	a HASIN	1 mis	2/7(//)
<i>y</i>	Chata	31. Date filed (Month, Pay, Year)	32. Registrar's Signatu	1. 10	11800	e istyce	Man	1 111/6	1170
Re	State gistrar	MAY 2 1 2	UU4 Janeer .	A. A.	with	•			

			1 - For State Registrar	St	ate of M	larylan				ealth a	and Me	ental Hy	giene	20	06	182	285
	Physici /Medio		1. Decedent's Name (First, Middle Supin Gin Sh	ien				45 035	7	lti		2. Date of De Month May	24	, 2	Year 2004	3. Time of 1:20	Death O
	Examin Funeral Director	ier	4a. Fecility Name (If not institution Casey House 5. Social Security Number	6. Sex	7. A	ge (In yrs.	last birthday)	Rocl	cvill r 1 Year	e If Under 2 Hours	24 Hrs.	8. Date of Bir (Month, Da May 20	th	ont	y of Death Somer 9. Birthe Cour	place (State or	r Foreign
	D D	tor	213-13-2222 Usual Residence of Decedent 10a. State 10b. County Maryland Montg	omery			y, Town or Lo thersb		l			ay 20	<u>, 17</u>			0d. Inside Cit	•
	th with the 23a or 28s	ai Direc	10e. Street and Number 8909 Shady Grov	e Cou	rt			10f. Z	p Code				10g. Cit Chi		What Cou	ntry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland D-partment of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event. Its Medical Evarifier must be notified at other.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ied 1	Vas Deceden Amed Forces Yes 20 Yes, Give Year or Dates	? No	ĺ	Was Dece If Yes, spi 1 Yes		ispanic Orig in, Mexican Specify:	gin? (Spec , Puerto R	cify Yes or No lican, etc.))-		ce - Americ ck, White, ^{fy:} Chi		
21215-0036	swithin 72 ho liene. r than "natur the Medical	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12)	st grade cor	n npleted) College (1-4or 4	5+)	life.	kind of w	ork done d use retired	during most	of workin	g			Business/In Home	dustry	
Maryland 2	nould be filed I Mental Hyg narked othe natic event,	To Be C	17. Father's Name (First, Middle, Gi 19a. Informant's Name/Relations	n	Dei-ea)		10h Mail	o Addres		Yu L	an 2	(First, Middle Zhen Route Numb				Codel	
	ss 1 and 2 shoot Health and item 27 Is nor other traun		Dianna Yan/daug 20a. Method of Disposition 1 □ Burial XXCremation	hter		20b. P		Shad	Gro	ve Co		Gaithe:	rsbu	rg,		0877	
Baltimore,	permit. Page D-partment Importent: If any injury o		*4 □ Donation 5 □ Other (S	pecify)	antte.	W.	G	2. Name a	nd Addres Home	ory ss of Facility Crem	2004 y ation	4 n Serv:	ice	P.0). Bo:		1000
	Physician		23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition	only one ca	ons that cause tuse on each	ed the deat line.	h. Do not en	ter the mo	de of dyin	g, such as	cardiac or	e P.A. respiratory a	rrest,	rks		Approximate Interval Bety Onset and D	e ween
,00	Medical Examiner hysicien and the prival-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Eine Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or a Dronar Due to (or a Due to (or a	s a conseq y Arte s a conseq	uence of): ery Di uence of):						_			ears	
.O. Box 68760,	ath certific ttending p or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		f yes, outcom l ∐Live birth l □Pregnant g □ Unknown	2 Feta	I death 3	⊒Ectopic ⊒ Other (s	oregnancy pecify)						ate of deliver		'ear
s, D	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditi	ons contribu	uting to death	but not res	ulting in the u	underlying	cause give	en in Part I.						ne cause of department of department of department of the cause of the cause of department of the cause	
al Record	The law ate has b page 2 s	e Completed	25. Was case referred to medica							OF Place	at Dogth		psy ormed? 2 XNo		Were auto prior to co death? 1 \(\text{Yes}	psy findings a mpletion of ca 2 \(\text{No} \)	available ause of
ion of Vital	ding Phys h. After this funeral di	ToB	examiner? 1 Yes XXNo 27. Manner of Death 1 XNatural 5 Pendia 2 Accident invest	Hosp 2	ital: 1 □ Inpa 8a. Date of In (Month, C		ER/Outpatie 28b. Time of Injury		28c. Injun Worl	er: 4□ Nu	rsing Hom	e 5 Resi	dence			whospi	ce
Division	i dite	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 2		etc. (Specif	(y) 					8f. Location (City or To	wn, State	9)			ber,
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical	(Check only 2 Medical one)	Examiner:	On the basis and manner:	of examina	owledge, dea ation and/or in	rvestigatio	at the tin n, in my o	pinion, deal	d place, ar	nd due to the d at the time,	date and	d place,	and due to	tated. the cause(s) Day, Year))
	viit To con		29b. Signature and title of certific	✓	<u></u>])3563						, 200		
3	Ø		30. Name and address of person Joseph Kaplan	6001	Muncas	ter M	ill Ro		Rockv	ille,	Mar	yland :	2085	5			
	Sta Regist	ate rar	31. Date filed (Month, Day, Year, MAY 2	6 2004	32. 19 S	trar's Signa	A.	bert	,								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 9 200+ Year MARCH **Physician** 0445M SULLIVAN HIMES RUBYE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NICOMICO 5/21/364NI REGIONAL MEDICAL PENINSULA If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2 F Director 579-01-5187 5/26/1915 Tennesee Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits the Medical Exertings must be notified at 1XYes 2□No Director Snow Hill Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 Items 23a 102 S. Church Street 21863 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 XWidowed 4 ☐ Divorced white "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Hygiene. Management Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Importent: if Item 27 is marked oth any injury or other traumatic event 2008: Ruby Hix Watt T. Himes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra M. Wilkinson (daughter) 102 S. Church St., Snow Hill, MD 21863 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 3/11/2004 ¹ 4 □ Donation 5 □ Other (Specify) Salisbury, Maryland Salisbury Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Melson Funeral Home, P.A. 103 Linden Ave., Pocomoke City, MD 21851 buchael Dean Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SUBDURAL HEMATIONA IWEEK ADOR TO A DOCUMENT /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence off Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FIGRILLATION / COMMITIN 1 ☐ Yes 2 25 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an autopsy performed? 1□ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury Natural 5 Pending Subject fell March 2,2004 Unknown 1 ☐ Yes 2 No death. 2X Accident investigation the 1 Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building atc. (Specify) Home 28f. Location (Street and Number or Rural Route Number, City or Town, State) 430 W. Market Street, Snow Hill, MD in by t 4 - Homicide within 24 hours after To the Funerel Dire 1 SX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D33737 HOX teen mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POBERT FERBER, MO; 100 E. CARROLL STY SALISAVRY, MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

				ate of Marylan	d / Depa	artment c	of Health an	nd Mental Hyg	iene	
			State Registrar Decedent's Name (First, Middle, Last)		Cel	Tificate	of Death	2. Date of Deat	_{eg. No.} 200	3. Time of Death
ı	Physici		William Arthur The	omas. dr.				May 26,	Day Y	6:25 P M
	/Medic Examir		4a. Facility Name (If not institution, give street		-	4b. City, Tov	vn, or Location of D		4c. County of I	
ı			Southern Maryland Ho	ospital		С	linton		Prince	George's
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Y Months D		Min. (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	78	113.			Sept. 28	, 1925	Maryland
	yland how		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Ba-f s	ctol	Maryland Prince Georg	ge's For	estvil	1e				1 ☐ Yes 🗶 ☐ No
	with th	Funeral Director	10e. Street and Number			10f. Zip Co		11	0g. Citizen of Wha	
	eath v	erai	2805 Phelps Avenue	as Decedent Ever in U.	S 13 V		20747	2 (Specify Yes or No.	USA 14 Page	American Indian,
0	riter d	Fun	Ar 1 □ Never Married 2 Married 1 [med Forces? ⊒Yes 2⊠No	1			? (Specify Yes or No- Puerto Rican, etc.)		White, etc.
2	ours a	d by	3 ☐ Widowed 4 ☐ Divorced Ye	Yes, Give ear or Dates:		1□Yes 2X	No Specify:		Specify:	White
9500-61212	"natu	lete	15. Decedent's Education (Specify only highest grade com	pleted)	16a. Deced (Give	lent's Usual O kind of work d	ccupation one during most of etired)	f working	16b. Kind of Busin	ess/Industry
717	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or items 23a or 28a-f show this the Medical Exacting transite indiffied at	Completed	Elementary/Secondary (0-12) Co	ollege (1-4or 5+)		rs Help		l P	rince Ge	orgesCounty
ō	m - 0 2	BeC	17. Father's Name (First, Middle, Last)			•		Name (First, Middle, A	Maiden Surname)	Education
Maryland	2 should be and Mental le marked (eumatic ev	To	William Arthur Thomas	s, Sr.				Elizabeth		
Mar	12 sh h and 7 le m treum		19a. Informant's Name/Relationship (Type, Pr	rint)				r Rural Route Number,		
<u>စ</u> ်	1 and Healt Iem 2		Mary E. Thomas 20a. Method of Disposition	20b. Pi	2805 lace of Dispo:	PNEIDS sition (Name of natory or other	Avenue,	Forestvill	e MD 20 20c. Location - City	
ē	Pages ent of nt: If ii		W☐ Burial 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)				netery 6-		linton,	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 ie marked any injury or other treumatic es once.		21. Signature of Funeral Service Licensee	M01391			ddress of Facility		, , , , , ,	
I)	201299		John Hyde		Ρ.	0. Box	k 156, Wa	ldorf, MD		
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final	is that caused the death	i. Do not ente	er the mode of	dying, such as car	rdiac or respiratory arre	est,	Approximate Interval Between Onset and Death
•	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequ	ence of):	7				
	Examiner		•							
	sit ad	iner	cause. Enter Underlying	Due to (or as a consequ	ience of):					
	be executed ician and burial-transit	Examiner	that initiated events c	Due to (or as a consequ	ience of):					
2/PU	ate be executed hysician and the burial-transit	ical E	d							
٥		ed	IF FEMALE:				-			
X Q Q	ath ce	lan/I	23b. Was decedent pregnant 12 months?	yes, outcome of pregnar □Live birth 2 □ Fetal	death 3 [Ectopic pregn			23d. Date of Month	delivery Day Year
	the de y the a	Physician/M	1 Yes 2 No 4L	□Pregnant at time of de □Unknown	ath 5	Other (specify	/)			,
7	requires that the death certific een signed by the attending p hould be detached for use as	by Pr	Part II. Other significant conditions contributi	ng to death but not resu	ilting in the un	iderlying cause	given in Part I.	23e. Did tob	acco use contribut	e to the cause of death?
ords	w require been sig should b								s 2 No 3	Probably 4 Unknown
ပိုင်	A C S	Completed						24a. Was an autopsy	prior	autopsy findings available to completion of cause of
<u>ra</u>	Physician: The law r this certificate has t ral director, page 2 s							perform 1 Yes 2		n? Yes 2□ No
>	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospita	ıl: 1 ∰Hopatient 2 🗆 E	ER/Outpatient	3 DOA		Death Check on one		2
0	ig Phy ter this neral c	-	27. Manner of Death 28a		28b. Time of Injury		njury at Work?	28d. Describe hor		вреспу)
Vision	or Attending ifter death. Director: After in by the fune	catic	1	(,,		1 Yes 2 No			
2	or At after d Direct in by	Certification:	3 Suicide 6 Could not be determined 286	 Place of Injury - At hor building, etc. (Specify) 	me, farm, stre)	et, factory, off	ice	28f. Location (Str. City or Town,	eet and Number of State)	r Rural Route Number,
_	spitel		29a. Certifier 15 Certifying Physician	To the best of my know	wledge, death	occurred at th	e time, date and p	lace, and due to the car	use(s) and manne	r as stated.
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	ledical	(Check only 2 Medical Examiner: 0 one)	n the basis of examinati nd manner stated.	ion and/or inv	estigation, in n	ny opinion, death o	occurred at the time, da	te and place, and	due to the cause(s)
	To with	Σ	29b. Signature and title of certification	7200	7	29c. Lic	ense number	59 1	d. Date signed (M	onth, Day, Year)
<u>.</u>			30. Name and address of person who complete	ed cause of death (Item	23a) (Type 1	Print) 4	31 0	3001	47 -1	156
1	2010)	Repé Erace	7/11/		C1	noon	,111	2073	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 8 200	32. Registrar's Signat	ure	Speek 1		/		
	3.47		III/I NO LOO		1	-				

			For State Ragistrar	State of Ma		•		of H	ealth a		ental Hy	giene Reg. No	20	04	18289
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Lasi John Nelson 7 4a. Facility Name (If not institution, give 914 Main Str	omlinson, street and number)	Sr.		4b. City, 1		Location o	f Death	2. Date of De Month May 24	4, 2 4c.	004 County of		3. Time of Death 11:20 P ^M
	Funeral Director		Social Security Number 6. Se		93	last birthday) Yrs.	If Under Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da March	th	nne A 1911	9. Birthpl	ace (State or Foreign try) Land
	filad within 72 hours aftar death with the Maryland Hygiene. yther then "naturel", or Itams 23a or 28a-f show yther the Medical Examinar must be millified at	Director	10a. State 10b. County Maryland Anne Aru 10e. Street and Number		10c. City	y.Town or Lo			<i>.</i>				tizen of Wh	at Coun	
036	be filed within 72 hours after death with the Marylar tital Hygiene. Ind other then "naturel", or Itams 23a or 28a-f show other the medical Examinational tennified at	by Funeral Director	914 Main 11. Marital Status 1 Never Married 2 Married 3 WWidowed 4 Divorced	12. Was Decedent E Armed Forces? 1/17/9s 2 N H Yes, Give Year or Dates:		TT	Was Deced f Yes, spec			gin? (Spe , Puerto I	cify Yes or No Rican, etc.)		Unite 14. Race - Black, Specify:		an Indian,
Maryland 21215-0036	lad within 72 ho lygiene. her then "natur it, the Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 0 th	ucation de completed) College (1-4or 5	+)	(Give	dent's Usua kind of wor DO NOT us ired	k done d e retired,	turing most r Lay	er	ng (First, Middle		Cont	ract	
laryland	should ba and Mental Is markad o	To Be	John C. Tomlins 19a. Informant's Name/Relationship (7)	ype, Print)		1	•		Mi and Numbe	nnie or or Rura	Garnei	er, City o	or Town, St	ate, Zip	
Baltimore, N	8°5 = 9		Joan Richards (D 20a. Method of Disposition 1 M Murial 2 Cremation 3 C 4 Donation 5 Other (Specify,	Removal from State		Place of Disponentery, cremetery, cremetery	sition (Nam natory or ot tion (her place Ceme	ø May tery	28,		20c. Lo	ocation - C	ity or To Mar	wn, State y 1 and
Balt	permit. Pa Departmen Important: any injury		21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or compshock, or heart failure. List only of	the	0 5/	12 4	Alexar	ndria	a Fer	ryRo	ad, Cli	nto			633 01d nd 20735 Approximate Interval Between
760,	Physician hysician and physician and physician and physician and physician and physician and physician are physician at the physician are physician and physician are physician at the physician are physician and physician are physician and physician are physician and physician are physician are physician are physician are physician and physician are physician are physician are physician are physician and physician are physician and physician are physician and physician are physician are physician are physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are physician are physician are physician and physician are physician and physician are p	Ilcal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Cardi Due to (or as	a conseq a conseq	uence of):	rhy ic (ard	nja so Vo	styl	een d	Lise	ase	5	Onset and Death minu tes
P.O. Box 68	Physician: The law requires that the death certificate be exacuted this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Feta	Ideath 3	Ectopic pro						23d. Date Month		ry Day Year
Records, P	w requires that been signad b should be deta		Part II. Other significant conditions of	•			ndertying ca 131aa								e cause of death? ably 4 (Tunknown
al Reco	ysician: The lawr is certificate has be director, page 2 sh	Completed by	Dementia								1□ Yes	psy ormed? 2 No	pride	or to con ath?	osy findings available inpletion of cause of
Division of Vital	fter	atlon; To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Dat		ER/Outpatier 28b. Time o Injury		8c. Injury Work	^{er:} 4 □ Nu ⁄at	rsing Hor 2 No	ne 5 ∏Resi Resi 28d. Describe	dence how inju	ry occurred	i	
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Diractor: After th completely filled in by the funeral	al Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc /sicien: To the best	c. (Specif	(y) 			ne, date an		City or To	wn, State	9)		Route Number,
	To the Hos within 24 hu To the Fun completely	Medical	(Check only 2 Medical Examone) 29b. Signature and title of certifier	iner: On the basis of and manner sta	examina	ition and/or in	vestigation,	in my op	oinion, deal	th occurre	ed at the time,	date and 29d. Da	d place, an te signed (d due to Month, L	the cause(s) Day, Year)
Ş	2119		30. Name and address of person who of 5851 ~ Dea	completed cause of d	eath (Item	n 23a) (Type,	Drint)	CALL	N .	C .	SUR.	DN	A	207	2004
	Sta Registi		31. Date filed (Month, Day, Year)	32. Redistri	ar's Signa	ture	fresh	•	ط	1566	15	1711			21

State of Maryland / Department of Health and Mental Hygiene 2004 18290 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month 200^{Year} 20, May 2:00 PM Mary Loar Ustaszewski /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Frederick Frederick Beverly Healthcare If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) If Under 1 Year 8. Date of Birth (Month, Dey, Yeer) May 12, 1914 **Funeral** Birthplace (State or Foreign Country) Days 1 ☐ M 2 🔀 F Months Hours 90 214-07-3979 Yrs Director Maryland Usuel Residence of Decedent filed within 72 hours after deeth with the Marylend 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick Director 1XXYes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 30 North Place 21701 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∑XYes 2 □ No WWII If Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: White è Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiane. Factory Worker Textiles 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) end Mantal h Be 2 should be Shadrock Franklin Loar Mary Elizabeth Buskirk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Pages 1 end 2 ment of Health f Health Deborah Walsh / Great-niece 628 Morgana Dr., Sheperdstown, WV 25443 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Mavate24. Depentment of Important: If It any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Resthaven Memorial Gardens 2004 Frederick, Maryland 21. Signature of Funeral Service Licensee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 ications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be axecuted for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown sellersus þ Be Completed 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No octor: After this certific by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Linursing Home 5 - Residence 6 - Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending aftar deeth. investigetion 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) within 24 hours 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) W. 9th St, Fachenily Med 21707 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State 2 4 2004 Registrar

DHMH 16 Rev 6/95

Box 68760.

Records, P.O.

Division of Vital

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 23, **Physician** Alicia Jean Vickers 2004 12:00 A M /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Goodwill Mennonite Home Grantsville Garrett | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Pay, Year) | Oct 29, 1922 5. Social Security Number 7. Age (In yrs. last birthday) 81 Yrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 236-48-9208 West Virginia **Director** Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Items 23a or 28e-f show the Medical Examiner must be notified at MD McHenry 1 ☐ Yes 2 No Director Garrett 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21541 2976 Mosser Road USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. I ☐ Yes 2 🔏 No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No white ⋧ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within and Mental Hygiene. West Virginia Universi Elementary/Secondary (0-12) College (1-4or 5+) Secretary Housing Dept. 12 th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 Is marked oth eny injury or other treumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lloyd V. McConkey Daisy M. Crutchfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy J. Graham/daughter 2976 Mosser Rd., McHenry, MD 21541 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Beverly Hills Mem Gard. May 26,04 Morgantown, WV 22. Name and Address of Facility 21. Signature of Furieral Service Licensee Newman Funeral Homes, P.A., PO Box 275 179 Miller St., Grantsville, MD enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. Do not ei shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** week disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Records, P.O. Box 68760 Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9□ Unknown à Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by be 1 Tes 2 No 3 Probably peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only of Hospital: 1 ☐ Yes 2 No Other: ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gassell Hylmony Oakland, Md 21530 margare a 31. Date (iled (Month, Day, Year) 32. Registrar's Signature State 2 4 Registrar

DOS 04-3456 Joyce Vincent

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiere UU 4 18292

			1 - State Registrar	State of Ma	ar y tar	•		ate of l		- Ivientai i	Reg. N		
	Physici	an	1. Decedent's Name (First, Middle, Las Joyce Elai		ont					2. Date of I Month		ay Yeer	3. Time of Death
	/Medic	cal	4a. Facility Name (If not institution, give				4h Ci	Town or	Location of De	May		2004 c. County of Death	705 a
	Examir	ier	Easton Memorial					Easto		au i		Talbot	
	Funeral Director		5. Social Security Number 6. Social Security Number 221-24-5892	ex 7. Ag □ M 2 1 F		last birthday) 64 Yrs.	If Und Month	der 1 Year s Days	If Under 24 H Hours M		Birth Day, Yea 3 / 3 9	9. Birth Cou	place (State or Foreign intry) Ware
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Be-f sho	ctor	MD Carol	ine					eralsb	urg			1 ∑Yes 2 □ No
	th with th	ai Dire	10e. Street and Number Post Office B	ox 309			101.	Zip Code 2 1	1632			itizen of What Cou	
020	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural; or Itema 23a or 28e-f show eumatic event, it a Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		1		edent of Hoseify Cuba	ispanic Origin? n, Mexican, Pu Specify:	(Specify Yes or lento Rican, etc.)	No-	14. Race - Amer Black, White Specify: Wh	, etc.
Mar ylaild 2 12 13-0036	within 72 ho ene. then "natur re Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or 5	i+)		dent's University of NOT	vork done d use retired	ation during most of v	vorking	Ac	Kind of Business/l me Mark tail Gr	ets/
ומומע	ild be filed lental Hygi ked other ic event, I	To Be Co	17. Father's Name (First, Middle, Last) Dale Mitchell							Name (First, Midd Mitchel		on Sumame)	
a	2 should and Men is marke reumatic		19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	g Addre	ss (Street a	and Number or	Rural Route Nun	ber, City	or Town, State, Z	p Code)
	and and mostly mostly her tr		Herman Vincent	/Spouse	100h D							MD 216	
paimine,	permit. Pages 1 and 2 should Deportment of Health and Men Important: If Item 27 is marke any injury or other treumatic once.		20a. Method of Disposition 12 Burial 2 Cremation 3	Removal from State		Place of Dispo				Date / 0.4		Location - City or T	
	permit. Page Department of Important: If any injury or once.		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen 		E.								aryland ome, P.A
0	Per Per Suny Suny		23a. Part1. Enter the disease, or comp	Eskow		2 :	16	V. Ma	ain St	., Fede	ral	sburg,	MD 21632 Approximate
	certificate be executed duple by sicial and duple by sicial and harding physician and last as the burial-transit	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c. Due to (or as d.	a consequal	uence of):	eros	cler	otic co	voliova	SCU	las diseas	Onset and Death
á	death cer e attendir id for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	Ideath 3	Ectopic	pregnancy (specify)				23d. Date of delive	ery Day Year
_	law requires thet the as been signed by th 2 should be detache	þ	Part II. Other significent conditions co	ontributing to death be	ut not resi	ulting in the ur	ndertying	cause give	en in Part I.		l tobacco		he cause of death?
ב	The ate h page	Completed								24a. Wa aut per Yes	opsy formed?	prior to co	psy findings available impletion of cause of 2 No
7 150	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	ar.	eath (Check only			
5	ਦ = <u>ख</u>	: To	1 X Yes 2 ☐ No 27. Manner of Death	1 Inpatie	ry	ER/Outpatien 28b. Time of	t 3.Ţ <u>x</u>	28c. Injury Work	4 Nursing	Home 5 ☐ Re 28d. Describe		6 ☐Other (Special ary occurred	(y)
5	토울글램	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	y Year)	Injury	М		? Yes 2 □ No				
		Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	ury - At ho c. (Specify	ome, farm, stre	eet, fact	ory, office		28f. Location City or T	(Street a own, Stat	nd Number or Rura e)	al Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in I	edical C		vsicien: To the best of iner: On the basis of and manner sta	examina								
	To the within 2 To the Complet	Me	29b. Signature and title of certifier	om.i	R	20al.	2	9c. License				ate signed (Month, 23, 200	
	Sta	te	30 Name and address of person who of the case of the c	completed cause of the completed cause of the completed cause of the complete cause of the cause of	311	AKM		111 P	enn Str	eet, Bal	timo	ore, Mary	land 21201

			1 - For State Registrar	State of Maryland / I		rtment of H tificate of L			ene g. No. 200	4 18293
	Phýsici /Medio			dward Watkins				2. Date of Death Month May 23	Day Yes	7:15P M
	Examir Funeral	ier	4a. Fecility Name (If not institution, give s Northampton Mano 5. Social Security Number 6. Sex	r Health Care		4b. City, Town, or Freder If Under 1 Year Months Days	ick	8. Date of Birth (Month, Day,		
	Director Mou		214-36-3637 Usuel Residence of Decedent 10a. State 10b. County	73	Yrs.	cation		May 10,	1931 Ma	ryland 10d. Inside City Limits
	with the Mar a or 28a-f a be notified	Director	Maryland Frederic		ovi	10f. Zip Code	1770	10	og. Citizen of What	
920	be filed within 72 hours after death with the Maryland nat Hygiene. Identity them "natural", or flems 23e or 28e-f show event, the Medical Examiner must be notified at	by Funeral Director	3908 Shakespeare 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	WAY 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 27 No If Yes, Give Year or Dates:				Specify Yes or No- rto Rican, etc.)	14. Race - A Black, W	mencan Indian, /hite, etc.
21215-0036	e filed within 72 hoi al Hygiene. i other than "naturi vent, the Madical I	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12		(Give :	lent's Usual Occupa kind of work done o DO NOT use retired	furing most of w	orking 1	6b. Kind of Busine Dairy	ss/Industry
Maryland	should be filed nd Mental Hygi marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Granville W. W. 19a. Informant's Name/Relationship (Ty	atkins (pe, Print) 191	b. Mailir	g Address (Street	Dorot	me (First, Middle, M ny Louise Jural Route Number,	Hawkin	
-	es 1 and 2 of Health a filtern 27 la r other trau		Ardean Mullinix W 20a. Method of Disposition 1 ABurial 2 Cremation 3 P 4 Departion 5 Other (Specify)	atkins - Wife 20b. Place comments comments	of Dispor	sition (Name of natory or other place	θ)		Oc. Location - City	or Town, State
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Fundral Service Linens. **Novert** 23a. Part1. Enter the disease, or complete the complete	00) 7 //	/ 22 O.		leswort	h P.A., Fu	ineral Ho	
50,	Physician /Medical Examiner Inuial-Iransit	I Examiner	shock, or heart failure. List only or Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Onemic Due to (or as a consequence Onemic	ACLU of): rey of):			disease		Intervat Between Onset and Death
.O. Box 68760	death certificate e attending phy id for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d		Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
Records, P.	equires that en signed ould be de	þ	Part II. Other significant conditions con		in the ur	nderlying cause give	en in Part I.	23e. Did tob 1 ☐ Ye		e to the cause of death? Probably 4 Unknown
tal Reco	The ate h page	e Completed	25. Was case referred to medical				26 Place of D	24a. Was an autopsy perform 1 Yes 2 eath (Check only one	prior death	
on of Vital	ing Phys After this uneral dir	ToB	examiner? 1		Outpatien Time of Injury	28c. Injury Wor	er: 4 Nursing	Home 5 Reside	nce 6 Other (S	Specify)
Division	itel or Attending urs after death. ral Director: Afte iled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, f building, etc. (Specify)				City or Town	, State)	r Rural Route Number,
-0	To the Hospitel or within 24 hours after To the Funeral Director completely filled in b	Medical		sicien: To the best of my knowledginer: On the basis of examination a and manner stated.			pinion, death oc	curred at the time, da		due to the cause(s)
			30. Name and ddres of person who co	ompleted cause of death (Item 23a)	ı) (Type,	Print	2746	Toda	5-dE	D-04
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	101	A L	e itve	rieger	1CK P	19 01101

-354/ 0	For State of Maryla		artment of H		•		IC.
	1 - State Registrar		rtificate of L			20 (14 18296
	Decedent's Name (First, Middle, Last)				2. Date of Death	j. 140.	3. Time of Death
Physician /Medical	GABRIEL M. WORTHINGTON		-		Month MAY		004 2:06p M
Examiner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c. County of	
	PRINCE GEORGE'S HOSPITAL CENT		CHEVERI				GEORGE'S
Funeral Director	NOW OUT	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear)	Birthplace (State or Foreign Country)
	Usual Residence of Decedent		5 8		DEC 18 2	2003 N	Maryland
how		City, Town or Lo	ocation				10d. Inside City Limits
e Ma Sa-f a fiffied	Maryland Charles	Waldorf					1 ☐ Yes 2 ☐ No
with the Mar a or 28a-f a be notified	10e. Street and Number		10f. Zip Code		10ç	. Citizen of Wh	at Country?
s 23a	10532 Beachwood Drive	110	20601			USA	
fitter death veritams 23subsectivals	11. Marital Status 12. Was Decedent Ever in Amed Forces? ↑★ Never Married 2 Married 1 1 Yes 2 No	1 U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto F	cify Yes or No- Rican, etc.)		American Indian, White, etc.
ons at urs at al., or sail, or	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1□ Yes 2🗓 No	Specify:		Specify:	White
Maryland 21215-0036 Maryland 212015-0036 at 2 should be filed within 72 hours after death with the Maryland at 2 should be filed within 72 hours after death with the Maryland it is marked other than "natural", or itams 23a or 28a-f ahow ritraumatic avant, the Marical Exacultant: sast by natified at To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupa	tion	16	b. Kind of Busir	ness/Industry
within see.	Elementary/Secondary (0-12) College (1-4or 5+)	life.	kind of work done di DO NOT use retired)	uring most of workin			•
e filed within at Hygiene, other than vant, the Museus, and Se Compl	None 17. Father's Name (First, Middle, Last)	None		40.14.4.4.1		ne	
and the final Hed out ed out				18. Mother's Name			
arylar should bu nd Menta narked umatic av	Corey P. Worthington 19a. Informant's Name/Relationship (Type, Print)	19b Mailir	ng Address (Street a	Darra Coc			ata Zin Cadal
Ma 2 sulth ar lith ar traus	Corey P. Worthington (Father)		2 Beachwo				
otha	20a. Method of Disposition 20b		sition (Name of natory or other place				ty or Town, State
Pages nent of nnt: if it iry or o	1 XBurial 2 □ Cremation 3 □ Removal from State 1 □ Dogation 5 □ Other (Specify)	inity M	em. Garde:	ns ¦6–1–0	4 Wa	ldorf,	MD
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men Important: if item 27 is marke any injury or other treumatic. singe.	21. Signalure Fun MO0173	22	. Name and Address	of FacilityEber	wein Fun	eral Se	rvices
m 89 2 2 8 9	John fi du		433 White				20695
* *	23a. Part. Enter the disease, or complications that caused the deshible, or heart failure. List only one cause on each line.	eath. Do not ente	er the mode of dying	, such as cardiac or	respiratory arrest	,	Approximate Interval Between
Fnysician	Immediate Cause (Final disase or condition resulting in death)	<u>`</u>					Onset and Death
/Medical Examiner	Due to (1 r as a cons	equence of):		(F)			
	Sequentially list conditions, if any, leading to immediate b. Tue to (or as a cons	sequence D	eumon	ارم			
executed executed in and ial-transit Examiner	cause. Enter Uncertying Cause (Disease or injury that initiated events						
O, exec an an rial-tr	resulting in death) Last Due to (or as a cons	equence of):					
8760, sate be executed hysician and the burial-transit	d						
P.O. Box 68 hat the death certifica d by the attending pr letached for use as it	IF FEMALE:						
Box eath cert attending for use a	23b. Was decedent pregnant in the past 12 months?	etal death 3 □	Ectopic pregnancy			23d. Date of Month	f delivery Day Year
the de ached	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time o 9 ☐ Unknown 9 ☐ Unknown	rdeath 5L	Other (specify)				24)
	Pacti. Other significant conditions contributing to death but not r	esulting in the ur	nderlying cause giver	in Part I.	23e. Did tobac	co use contribu	te to the cause of death?
cords w require. been sig should be	tailure tothrive				1 🗆 Yes	5 NO 3	Probably 4 Unknown
al Records, The law requires t cate has been signe page 2 should be Completed by					24a. Was an	24b. Wer	e autopsy findings available
					autopsy performed	deat	r to completion of cause of h? Yes 2 □ No
f Vital Re ysician: The ysician: The director, page To Be Com	25. Was case referred to medical examiner?			26. Place of Death		VIO	25110
0 5 5 7	Yes 2 No Hospital: 1 Inpatient 2	☐ ER/Outpatient	t 3□ DOA Other	4 Nursing Hom			Specify)
Division of Vita to Attanding Physician: after death. Director: After this certification by the tuneral director. In by the tuneral director.	27. Manner of Death 1 Natural 5 ☐ Pending (Month, Day Year)	28b. Time of Injury	28c. Injury a Work?		3d. Describe how i	njury occurred	
OIVISION or Attantate death Diractor: in by the	2 Accident investigation 3 Suicide 6 Could not be determined determined	home farm etre		es 2 No	of Location (Street	tand Number	r Rural Route Number.
F Page I	4 Homicide determined 288. Place of injury - At building, etc. (Special Control of the Control o	city)	out, ractory, critica		City or Town, S	tate)	Thurst Hobie Namber,
To the Hospital within 24 hours a To the Funaral I I completely filled Medical Ce	29a. Certifier 1 ☐ Certifying Physicien: To the best of my k	nowledge, death	occurred at the time	, date and place, an	d due to the caus	e(s) and manne	r as stated.
the Hosp hin 24 hou the Funa npletely fil	(Check only one) 2 Medical Examiner: On the basis of examinand manner stated.	nation and/or inv	estigation, in my opir	nion, death occurred	at the time, date	and place, and	due to the cause(s)
To the within To that comple	29b. Signature and title of certifie)nn.	29c. License r				onth, Day, Year)
	John Mona-to	Helin	A CUME	<u> </u>	MZ	AX 27	7, 2004
5BI	35. Name and address of person who completed cause of dean (It	tem 23a) (Type, F	Print) L Penn Str	mat Pali	-imo	(a.s1	1 21201
State	31. Date filed (Month, Day, Year) 32 Registrar's Sign	1.0	L TOTH OU	.ccr, ball	THOTE, N	атутапс	1 ZIZUI
Registrar	MAY 2 8 2004 4	SO SE					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day May 25, 2004 Rose Ann White 11:45 Am 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Millennium Health & Rehabilitation Center Forestville Prince George's 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 1□ M XXF Months Hours Days 66 297 32 2642 April 12, 1938 Ohio Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County YN Yes 2□No Maryland Prince George's Morningside 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 6702 Poplar Road 20746 <u>United States</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give ĀĀ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No XX Specify: Specify: 3 ₩idowed 4 Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Resident Manager Bryant Woods Apt. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNKNOWN Helen E. Gerz 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wanda Belfield (Daughter) 6702 Poplar Road, Morningside, Maryland 20746 20b. Place of Disposition (Name of cemetery, cremetory or other place) June 1. Date 2004 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Washington National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licensee any E. Hedgman Alexandria Ferry Road, Clinton, Maryland 20735 1374 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death a. ANOXIC ENCEPHALOPATHY Due to (or as e consequence of): DIABETES MELLITUS Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 Yes 25 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Mursing Home 5 - Residence 6 - Other (Specify) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Injury

The law requires that the death certificate be executed attending physician end for use es the bunel-transit page 2 should the funeral director, Certification: To

Physician

Medical **Examiner**

Physician/Medical Examiner

2

Completed

Be

Medical

State Registrar

Physician

/Medical

Examiner

Directo

Funeral

þ

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumetic event, "he Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

27. Manner of Death 1 Natural 4 - Homicide

25n Certifier (Check only

25. Was case referred to medical examiner? 1 Yes 2 No

> investigation 2 Accident 6 Could not be determined 3 Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

1 🗌 Yes

2 🗆 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) **Certifying Physician: To the best of my knowledge, death cogured at the time, date and place, and due to the nause(s) and manner as stated.

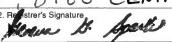
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of pertifier

29c. License number D 52900 29d. Date signed (Month, Day, Year) 5-25-2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8705 CENTRAL AU. H301, LANDOVER MD MomoH

31. Date filed (Month, Day, Year)



DHMH 16 Rev 6/95

Hospital or Attanding Physician: within 24 hours efter death.

To tha Funaral Director: Al
completely filled in by the fu

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Reg. No Z Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 7:15 A.M 2004 21 CHARLES DELBERT WILES Jr. May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett County Memorial Hospital Oakland Garrett 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 12/6/1929 9. Birthplace (State or Foreign Country)
Rowlesburg, W 5. Social Security Number 6. Sex **Funeral** 1 MM 2□F Director 74 236-4**8-**9517 Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show 1 ☐ Yes 2 ☐ No Director WV Preston Aurora 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26706 PO Box 29 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ø Yes 2 □ No If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☐ No Specify: Specify: white δ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Coal Miner Coal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Health and Mental other traumatic Charles Delbert Wiles Edna Loctton Wiles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 29, Aurora, WV 26706 Carolyn Wiles 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Important: If it any injury or or once. 5/24/2004 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery Aurora, 21. Signature pf Fineral Service 22. Name and Address of Facility
Arthur H. Wright Funeral Home 26764 105 Highland Ávenue, Terra Alta, WV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Chronic Obstructive Pulmonary Disease Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and ul-transit The law requires that the death certificate be executed Due to (or as a consequence of): by the attending physician a tached for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) □Yes 2□No detached 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Colon Cancer 1 X Yes 2 No 3 Probably 4 Unknown Completed Sepsis 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No page 2 autopsy performed? res 20 No certificate 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No ပ္ 1 🗌 Yes 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 hours after death.

-uneral Director: After this
ely filled in by the funeral di this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0033464 May 21,**200**4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Μ. Coughlin, M.D. PO Box 8, Eglon, WV 26716 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

	1 - For State Registrar	State of Maryland / I	Department of Health and Certificate of Death	Mental Hygier	-2000 + 1820
Physiciar /Medica	TIGE Y DECOME WALL			2. Date of Death Month	Day Year 3. Time of Death
Examine	and the second s	street and number) Nursing Home	4b. City, Town, or Location of Deat Boonsbore		4c. County of Deeth Washington
Funeral Director	5. Social Security Number 6. Se 219-05-2413	7. Age (In yrs. last bir	Yrs. If Under 1 Year If Under 24 Hrs Months Days Hours Min.		921 Sirthplece (State or Foreign Maryland
death with the Maryland ms 23a or 28a-f show Lindst be routilised at	10a. State 10b. County	10c. City, Tow	n or Location Boonsboro		10d. Inside City Limits 1 ☐ Yes 2 █No
uth with the Mar 23a or 28a-fal	10e. Street and Number 20935 San Mar Roa	ad	10f. Zip Code 21713	10g. (Citizen of What Country?
O36 Ours after all, or its	3 ⊠Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 Yes 2 \bigsim No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. Item 27 is marked other than "natural", or ite other traumatic event, the Middial Exprints To Be Completed by Eur	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+) 0	Decedent's Usual Docupation (Give kind of work done during most of work life. DO NOT use retired) parts handler	rking 16b.	Kind of Business/Industry
Maryland 212- Maryland 212- nd 2 should be filed within the and Mental Hygiene. To its marked other than traumetic event, the Maryland Hygiene.	17. Father's Name (First, Middle, Last) Fred G. Reed		Martha	ne (First, Middle, Maide Ellen Sinbo	en Sumame) Ower
ore, Mar	19a. Informant's Name/Relationship (Ty Nancy DuBois - dau 20a. Method of Disposition	ighter 20b. Place of	Mailing Address (Street and Number or Ru 20935 San Mar Rd., Be Disposition (Name of	oonsboro, N	
altim m.t. Pag pa tmend portent: y injury	1X Burial 2 ☐ Cremation 3 ☐ P '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral-Bervice License	Cedar	Lawn Mem. Park 5/2 22. Name and Address of Facility M		agerstown, Maryland ERAL HOME
	23a. Part I. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	cations that caused the death. Do recause on each line.	415 E. Wilson Blvd not enter the mode of dying, such as cardiac	., Hagersto	
S8760, Icate be executed physician and sthe burial-transit sthe burial-transit calcal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of Due to (or as a consequence of	ή.		2 respects
Records, P.O. Box 6 The law requires that the death certific te has been signed by the attending page 2 should be detached for use as ompleted by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
Cords, P	Part II. Other significant conditions con	tributing to death but not resulting in	the underlying cause given in Part I.		use contribute to the cause of death? 2 No 3 Probably 4 Unknown
al Record The law requir cate has been s page 2 should Completed	anex	retix		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Division of Vital Records, tor Attanding Physician: The law requires that deter death. Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 ER/Out 28a. Date of Injury (Month, Day Year) 28b. T	patient 3 DDA Other: 4 Nursing Ho	th (Check only one) ome 5 Residence 28d. Describe how inju	
2 5 2 9 C	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)		City or Town, Star	,
o the Hospi thin 24 hou on the Funer impletely fill	one)	ician: To the best of my knowledge, ler: On the basis of examination and and manner stated.	death occurred at the time, date and place, for investigation, in my opinion, death occur	red at the time, date ar	nd place, and due to the cause(s)
	29b. Signatury and title of certifier	- Prus	D (9824)	29d. Di	ate signed (Month, Day, Year)
STA	30. Name and address of person who con	mpleted cause of death (Item 23a) (A 3 (32. Registrar's Signature		HAGERS	Tour Maryo
State Registrar	MAY 2 5 20	04 Section of	Spelie		. ,

	è	1	1 - State Registrar	ate of Maryland / Dep Ce	artment of Health and Martificate of Death	lental Hygie	ne No. 2004 18298
	Physici /Medio	al	Decedent's Name (First, Middle, Last) Kathryn Louise Wag As. Facility Name (If not institution, give street)		4b. City, Town, or Location of Death	2. Date of Death Month	Day Year 3. Time of Death P 26, 2004 2:00 M 4c. County of Death
	Examin Funeral Director	ier	Washington County House Social Security Number 6. Sex 162 - 22 - 7262	ospital 7. Age (In yrs. last birthday	Hagerstown If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	Washington
	Maryland e-f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Washington	10c. City, Town or L Hagers	ocation		10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	ith with the 23e or 28	Funeral Director	10e. Street and Number 19800 Tranquility	Circle	10f. Zip Code 21742	10g.	Citizen of What Country? USA
9036	iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If item 27 is marked other then "netural", or items 23e or 28e-f show or other treumetic event, the Macinal Exam.	Ď	1 Never Married 2 Married 1	as Decedent Ever in U.S. med Forces? Tyes 2 No Yes, Give Nar or Dates:	Was Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ▼ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	be filed within 72 ho al Hygiene. 1 other then "netu went, 'the western	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) Co	pleted) (Give life. bllege (1-4or 5+)	dent's Usual Occupation kind of work done during most of worki DO NOT use retired) cal Technician	ng	. Kind of Business/Industry
Maryland	should be filed ind Mental Hygi is marked other umetic event, II	To Be C	17. Father's Name (First, Middle, Last) Alvie James Wilson		18. Mother's Name	(First, Middle, Maid ine S. Pit	den Sumame)
	1 and 2 sho Health and tem 27 is m		19a. Informant's Name/Relationship (Type, Pr Jane L. Miller 20a. Method of Disposition	sister 780	ng Address (Street and Number or Rura S. Washington ST (Greencast1	
Baltimore,	permit. Pages 'Department of H Importent: If ite any injury or ot		1 \ Burial 2 □ Cremation 3 \ Remov 4 □ Donation 5 □ Other (Specify) 21. Signature of Jun ral Service Licensee	Fairviev	matory`or other place)	29 2004 Me 11er-Bower	ercersburg, PA
	Pnysician		23a Part1. Enter the disease, or complication shock/or heart failure. List only one cau Immediate Cause (Final disease or condition	s that caused the death. Do not en	ter the mode of dying, such as cardiac o		Approximate Interval Between Onset and Death
8760,	Medical Examiner whysician and the burial-transit	icai Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence of): END STAGE Due to (or as a consequence of): Due to (or as a consequence of):	ENAL DISEASE		
P.O. Box 68	death certific e attending p ed for use as	Physician/Med	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	sign d be	by	Part II. Other significant conditions contribut	ng to death but not resulting in the t	inderlying cause given in Part I.		ouse contribute to the cause of death? 2 No 3 Probably 4 Unknown
al Records,	The ate h page	e Completed	25. Was case referred to medical			24a. Was an autopsy performed 1 Yes 2 🕏	
ion of Vital	ding Phys n. After this funeral di	To B	examiner? 1 ☐ Yes 2 No Hospita	ll: 1 ☑Inpatient 2 ☐ ER/Outpatient. Date of Injury (Month, Day Year) Representation of the control of the co	The second secon		
Division	itel or Atte	Certification;	4 Homicide	b. Place of Injury - At home, farm, st building, etc. (Specify)		City or Town, St	
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical	(Check only 2 Medical Examiner: 0	To the best of my knowledge, deat n the basis of examination and/or in ind manner stated.	h occurred at the time, date and place, a vestigation, in my opinion, death occurred 29c. License number	ed at the time, date a	o(s) and manner as stated. and place, and due to the cause(s) Date signed (Month, Day, Year)
)	F3F8		30. Name and abdress of person who complete	ed cause of death (Item 23a) (Type	D 59055	A	1 21 2-1
	Sta	te	C (ARAN BROWNE) 31 Date filed (Month, Day, Year)	100 1293 (Type, 1293) (Type, 12		e. Itry	.md 21742
	Registr	ar	JUN 0 8 2004	Bours A p	contin .		

			1 - State of M Registrar		artment of Health and rtificate of Death		ene 2004	18299
			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physici /Medio		Richard Cowe	er White		MAY 16,	2004 Year	4:20 P M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dec	ath	4c. County of Death	
			24639 HOLSINGER LN		RIDGLEY		CAROLINE	E CO
	Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year If Under 24 Hi Months Days Hours Min		(ear) 9. Birthpi	lace (State or Foreign
	Director		220-32-8681A	66 Yrs.		September 9		yland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		11	Od. Inside City Limits
	Many f she	ō	Maryland Caroline	Ridge]	37			1 □ Yes 🛂 Ū No
	28a	Director	10e. Street and Number	idages	10f. Zip Code	10g	. Citizen of What Coun	trv?
	ours after death with the Marylan ral', or Itams 23s or 28s-f show Exerchar mast be rediffed at	<u></u>	24639 Holsinger Lane		21660	T.	United Stat	95
	death ms 2	Funeral	11. Marital Status 12. Was Decedent	Ever in U.S. 13.1	Was Decedent of Hispanic Origin?	Specify Yes or No-	14. Race - America	an Indian,
ڥ	or Itams	Ē	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 [5] If Yes, Give	No	f Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☑ No <i>Specify:</i>	eno Rican, etc.)	Black, White,	etc.
8	ral',	d by	3 Widowed 4 □ Divorced Year or Dates:		1 ☐ Yes 2 ☑ No Specify:		Specify: Caucas	ian
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-1 show ha Medigul Ezar, di ar mast ke mediliad at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of w	orking 16	b. Kind of Business/Ind	lustry
12	within ene. than	E C	Elementary/Secondary (0-12) College (1-4or s	5+)	DO NOT use retired)		Dankton	
	e filed withi al Hyglene. I other than vant, the M		12 HS Grad 17. Father's Name (First, Middle, Last)	Eoa	twright	ame (First, Middle, Ma	Boating	
an	d be antal	Be c						
Maryland	should be and Mental Is marked o	ို	Joseph Wright White 19a. Informant's Name/Relationship (Type, Print)		Margue Ing Address (Street and Number or F		ice Holsing	
	nd 2 allth a 27 ls r tra		James Christian White Brot		x 352, Cheswold,			
re,	of Heal		20a. Method of Disposition	20b. Place of Dispo	sition (Name of natory or other place)		c. Location - City or To	wn, State
Ë	Page nent c int: If		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)			/2004 D	over, Delav	ware
Baltimore,	permit. Pages 1 a Department of He Important: If itam any injury or otha		21. Signature of Funeral Service Libensee		Name and Address of Facility Oore Funeral Hom	e, P.A.	2.027 2014.	ware
			23a. Parl1. Enter the disease, or complications that caused	the death. Do not ent	2 South Second S	treet Den	ton, Maryla	and 21629 Approximate
ı			shock, or heart failure. List only one cause on each li			A A		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a consequence of):	ray of other	1 Worte		
	Examiner		Due to (or as	a consequence on.				
		Jer	Sequentially list conditions, 1 any, leading to immediate cause. Enter Underlying	a eurisequence of):				
	ocuted nd transi	Examln	that initiated events					
50,	oe execien a		resulting in death) Last Due to (or as	a consequence of):				
68760,	icate be executed physicien and s the burial-transit	edical	d					
		/Me	IF FEMALE: 23c. If yes, outcome	of pregnancy			22d Date of deliver	
Box	death certific e attending p id for use as	Physician/M	in the past 12 months?	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deliver Month	Day Year
0	0 0 0	nysi	1 Yes 2 No 9 Unknown 9 Unknown		- (-) //			
٣.	requires that the seen signed by th hould be detache	by P	Part II. Other significant conditions contributing to death b	ut not resulting in the ur	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the	e cause of death?
ğ	w require been sig should b					1 🗆 Yes	2 No 3 □ Proba	ably 4 □Unknown
Records,	law requas been 2 shoul	Completed				24a. Was an		sy findings available
Ä	he h	EO				autopsy performed	death?	opletion of cause of 2 ☐ No
Vital		Bec	25. Was case referred to medical examiner?		26. Place of De	eath (Check only one)	A	
of V	Physician: this certific ral director,	2	1 XYes 2 No Hospital: 1 ☐ Inpatie		t 3 DOA Cther: 4 Nursing	Home 5 ☐ Residence	e 6 V Other (Specify)	SCENE
		on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, Da)	ry 28b. Time of Injury	28c. Injury at Work?	28d. Describe how i	njury occurred	0 (
Sio	ten feat tor: the	catl	2 Accident investigation Security investigation 28.9 Place of Initialization	- 00	M 1 □ Yes 2 No	sayle	J 8101 F	elt
Division	F in it	Certification;	4 Homicide determined 286. Place of Injury	ury - At home, farm, stre c. (Specify)	set, factory, office	City or Town, S	t and Number or Rural tate)	Houte Number,
	purs and and and and and and and and and and	a C	29a. Certifier 1 Certifying Physicien: To the best	of my knowledge, death	occurred at the time, date and place	7657	1701SINSY	ted. 2/660
	a Hos 24 h	edica	(Check only 2 Medical Examiner: On the basis of and manner sta	examination and/or inv	restigation, in my opinion, death occ	surred at the time, date	and place, and due to	the cause(s)
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, D	Pay, Year)
)	-		1 () (skemi)		OCME	MA	Y 17, 2004	
			30. Name and oddress of person who completed cause of d	eath (Item 23a) (Type, I	111 Penn Stra	et. Baltim	ore, Marvl	and 21201
	Sta	te	31. Date filed (Month, Day, Year) 32. Registro	ar's Signature		oct, Editori	- CLO, IRILYI	
	Registr	ar	MAY 1 8 2004	Seed IS A	gossa -			

		1 - For State Registrar	State of Maryland	d / Depa		Health and	Mental Hyg	iene •g. No. 20	004 1831
Physic /Medi Exami	cal	Decedent's Name (First, Middle, Last, Mary M. Ziegle Aa. Facility Name (If not institution, give	er		4b. City, Town,	or Location of Dea	2. Date of Deal Month May		
Funeral Director		Frostburg Vill 5. Social Security Number 6. Sec. 172-34-7188			Frostk If Under 1 Year Months Days	If Under 24 Hr	. (Month, Day,		gany 9. Birthplace (State or Foreig Country) Maryland
Maryland a-f show	ctor	10a. State 10b. County Maryland Allegar	,	Frost			- 1.		10d. Inside City Limit
h with the 23a or 28	al Dire	10e. Street and Number 1 Kaylor Circle	2		10f. Zip Code 2153	2	1	0g. Citizen of Wh	at Country?
be tiled within 72 hours after death with the Maryland ital Hygiene. Id other than "naturel", or itams 23a or 28a-f show event, the Medical Exemple to notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🏿 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of f Yes, specify Cul I ☐ Yes 2√ No		Specify Yes or No- rto Rican, etc.)		American Indian, White, etc. White
within 72 hor ane. than "nature	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e co <i>mpleted)</i> College (1-4or 5+)	(Give	DO NOT use retir	during most of wood)	orking	16b. Kind of Busin	
should be filed within and Mental Hygiene. marked other than imatic event, the M	To Be Co	17. Father's Name (First, Middle, Last) William Thomas	Lewis		Homem	18. Mother's Na	ume (First, Middle, M et Ann R	•	
permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e pnce.		19a. Informant's Name/Relationship (Ty Dr. Gary A. Zie 20a. Method of Disposition	gler-Son	8805	Walnu	t Botto	Date	Mt. Cr	ate, <i>Zip Cod</i> e) awford, VA ity or Town, Stat 2 2841
permit. Pages 1 and 2 should be tiled within 72 hours at Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural; or any injury or other traumatic event, the Medical Evant. Ang.		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	temoval from State Hil	emetery, cren lcres	t Mem. Name and Addr	Park2,	2004 C	umberl	and, MD
Fnysician /Medical		23a. Part1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	Do not enti	302 Nater the mode of dy	ing, such as cardia	Service, Hwy Lav Icor Hespiratory arre IIII D	ale, Mi	Approximate Interval Between Onset and Death
ate be executed we have any storian and minal-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence. Due to (or as a consequence.	ence of):					
eath certifics attending pt for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 [Ectopic pregnand Other (specify)	у		23d. Date of Month	
e law requires that the de has been signed by the ge 2 should be detached	þ	Part II. Other significant conditions con	ntributing to death but not resu	ilting in the ur	nderlying cause g	ven in Part I.			ute to the cause of death?
: The law re cate has be page 2 sho	Completed						24a. Was ar autops perform 1 \(\text{Yes} \) 2	y prio	re autopsy findings available to completion of cause of th? Yes 2 200
sician certif rector	Be	25. Was case referred to medical examiner?	lospital:		Ot		ath (Check only one		
To the Hospital or Attending Physician: The law requires that the dwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	ation; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 E	ER/Outpatient 28b. Time of Injury	28c. Inju	4 X Nursing	Home 5 Reside 28d. Describe ho		
pital or Attuurs after de vrai Directo	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify)			City or Town	, State)	or Rural Route Number,
the Host in 24 ho the Fune ipletely fi	ledicai	(Check only 2 Medical Examination)	sician: To the best of my knowner: On the basis of examinati and manner stated.	viedge, death ion and/or inv	estigation, in my	opinion, death occ	urred at the time, da	ite and place, and	due to the cause(s)
To To To Com	Σ	29b. Signature and title of certifier	gh MI	0	29c. Licen				Month, Day, Year)
7	18	30. Name and address of person who co			Print) Wace	Fres	thure 1	MD215	32
Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signat		d ²	1	0		

DHMH 17 Rev 1/2001

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene? 0.01.

			For State	State of Marylan		nt of Health and <i>te of Death</i>			18301
			Registrar Decedent's Name (First, Middle, Last,		- Corumou		2. Date of Death		3. Time of Death
	Physicia /Medic		George	F. Adar	ns		3UUL	7 2004	2:45A.M
1	Examin		4a. Facility Name (If not institution, give	1		, Town, or Location of De		4c. County of Death	
			5. Social Security Number 6. Sec	Ch KAVEN 7. Age (In yrs.	South interest of the state of	AUTIMORE er 1 Year If Under 24 H	s. 8. Date of Birth	BAUTIM	ORE
Н	Funeral Director			M 2□F	Yrs. Months			Cour	place (State or Foreign ntry)
	D.		Usual Residence of Decedent		<u> </u>		7 0 - 90	1 Vernice	syrvaria
	arylar ehow	_	10a. State 10b. County	10c. Cit	y, Town or Location			1	1 ☐ Yes 2 12 No
	the M	ecto	10e. Street and Number	40	FORES.	ip Code	100	Citizen of What Cour	
	With With	ă	IMI Posson de	oldo Deixe)	21050	109.	LISA	My!
	death	Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	S. 13. Was Dec	edent of Hispanic Origin? ecify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Americ Black, White,	
90	be filed within 72 hours after death with the Maryland nat Hygiene. ad other than "naturel", or terms 23a or 28e-f show event, the Madical Examiner must be notified at		1 ☐ Never Married 2 Married	1 □Yes 2 No	1 ☐ Yes	1.2	nto rican, etc.)	Specify:	etc.
2-0036	hours turel,	ed by	3 Widowed 4 Divorced	Year or Dates:	16a. Decedent's Us	ual Occupation	16h	Kind of Business/In	21 TC ,
15	nin 72 n "nat	Completed	(Specify only highest grad	College (1-4or 5+)	(Give kind of w	ork done during most of w use retired)	orking	. A A	dustry
2121	giene.	E O	Elementary/Secondary (0-12)	5++	Kesoari	L Chemis	t Fe	deral Go	vernment
nd	be filed tal Hygird of other	Be	17. Father's Name (First, Middle, Last)	da	ı	18. Mother's N	ame (First, Middle, Maid	en Sumame)	
yla	should be nd Mental marked	2	19a Informant's N-me/Relationship (T)	dans	10h Mailing Addra	Heler) Latta	nZ10	Cadal
Maryland	2 2 20 20	1 8	Soul on Ado V	us-wife	1/V I PO	ss (Street and Number or	FO COS	- Lili M	0.2/057
-			20a. Method of Disposition	20b. F	Place of Disposition (N	ame of ather place)	Date 20c.	Location - City or To	own, State
E	空った デ		1 ☐ Burial 2 【**Cremation 3 ☐ F * 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	emetery, ciematory or OECH NS FUNERA	KCHAPEL 6-	10-04 F	orest H	11 MO
Baltimore ,	permit. Page Department o Importent: If any injury or once.		21. Signature of Funeral Service Licens	88 /	22. Name	and Address of Facility	NEWPORT-		EST HILL,
Ш	20 E E 9	7. 17.	grinberly (. Diviolita	FUANUS	FUNERALC	HAPEL-BEL	AIR. MI	
			23a. Part1. Enter the disease, or domple shock, or heart failure. List only of	ne cause on each line.	h. Do not enter the mo	ide of dying, such as cardi	ac or respiratory arrest,	100	Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a sinseq	alynume	s Demen	la		
	Examiner			Due to (or as a conseq	uence *).				
	STEET TO	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):				
	ecuter and trans	Examine	cause. Enter Underlying Cause (Legate or), u y that initiated events resulting in death) Last	Due to (or as a conseq	wanaa afk				
68760,	icate be executed physician and s the burial-transit	at E			usiios 01).				
687		edlcat		J					
Вох	leath certific attending p	M/M	230. Was decedent pregnant	.3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta		oregnancy		23d. Date of delive	•
	e deat he att	Physician/M	in the past 12 months?	4☐Pregnant at time of d 9☐ Unknown				Month	Day Year
P.0	that the de sed by the a detached		9 ☐ Unknown Part II. Other significant conditions co		ulting in the underlying	cause given in Part I	23e Did tobaco	o use contribute to the	he cause of death?
Records,	8 P. 9	d by	, <u>, , , , , , , , , , , , , , , , , , </u>			3	1 ☐ Yes		16
CO	w requir s been si should	lete					24a. Was an	24b. Were auto	psy findings available
Re	The lav	Completed					autopsy performed	prior to co death?	mpletion of cause of
Vital	(6 -	Bec	25. Was case referred to medical examiner?			26. Place of D	eath (Check only one)		
of V	Physicien: r this certific ral director,	2	1 ☐ Yes 21 No		ER/Outpatient 3 [Home 5 ☐ Residence		y)
	e e	lon	27. Manner of Delith 1 DNatural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at ' Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	Jury occurred	
Division	Attending or death. ector: After by the fune	ficat	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, street, facto		28f. Location (Street	and Number or Rura	al Route Number,
Ö	F 2 . E C	Certification	4 Homicide	building, etc. (Specif	(y)		City or Town, St	ate)	
	To the Hospitel of within 24 hours af To the Funerel D completely filled in		(Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina	owledge, death occurre	d at the time, date and pla in, in my opinion, death oc	ce, and due to the cause curred at the time, date a	(s) and manner as s and place, and due to	tated. o the cause(s)
	o the ithin 2 o the omplet	Medical	29b. Signature and title of certifier	and manner stated.	2	9c. License number	29d. l	Date signed (Month,	Day, Year)
	F ₹ F 8	1	Maitha 1 ain	11111111					
	10		30. Name and address of person who co	ompleted cause of death (Iter	n 23a) (Type, Print)	054578 ANON BYND	/		
	\	12	MARCHA C. MYM	UNDO, MD 3	1601 1001+1	AUON BIVD	BATTMORE	MD 0/23	7
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	dure				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2<u>004</u> Physician March 20, PM 1610 Justin Doyle Barnes, Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Hvattsville 7724 Emerson Road Hyatusviiii

If Under 24 Hrs.

| B. Date of Birth
| Days | Hours | Min. | Oct. | 20, 1965 | Washington, DC 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) 5. Social Security Number **Funeral** Months 1**∑**M 2□ F 38 YES 577-06-0966 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10b County 10a State r than "natural", or Items 23a or 28a-f shovers wedical Examiner must be notified at 1 Yes XXNO Hyattsville Director Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene important; if itam 27 is marked other than "natural", or items 23a any injury or other traumatic event. The Medical Examiner mass 1000. United States 7724 Emerson Road 20784 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: White Specify: þ 3 □ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Contractor 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jill Bayly Kidwell Justin Doyle Barnes, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7724 Emeron Rd., Hyattsville, MD 20784 Jill B. Kidwell-mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Trinity Memorial Gdns. 03-26-2004 Waldorf, Maryland 22. Name and Address of Facility
Huntt Funeral Home
P.O. Box 156, Waldorf, MD 20604 21. Signature of Funeral Service Licensee M00053 per dvr Mark G. Brohawn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bacterial Pneumonia With Abscess Formation **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine signed by the attending physician and dbe detached for use as the burial-transit certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ★ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

↑★ Yes 2□ No 24a. Was an autopsy performed? 2 🗆 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 LOther (Specify) Scene 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1X Yes 2 □ No this 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Certification: Manner of Death 1XXVatural after death. 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To tha 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie O.C.M.E. March 21, 2004 mpleted cause of death (Item 23a) (Type, Print) RUS 10 1 40 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

This is a re-created death certificate-if original is found please destroy original-gap 6/8/2003

DHMH 17 Rev 1/2001

ORIGINAL

hysici	ian	1. Decedent's Name (First, Middle, Las James Richard E						2. Date of Dea Month June 4,	Day Yes	3. Time of De
/Medi xamir		4a. Facility Name (If not institution, give			4b. C	ity, Town, or Lo	ocation of Death	Julie 4,	4c. County of D	11:00
		1238 Glyndon Ave			Ва	altimor	e		n/a	
ineral ector		5. Social Security Number 6. Se		(In yrs. last birth Y	day) If Un Mont		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day April 5	, 1947 M	Birthplece (State or I Country) ary Land
ind at	tor	10a. State 10b. County MD n/a		10c. City, Town Baltim						10d. Inside City
3a or 28a il barrolli	Funeral Director	10e. Street and Number 1238 Glyndon Ave				Zip Code 21223	· · · · · · · · · · · · · · · · · · ·	1	0g. Citizen of What	Country?
d other than insturat, or tems 23s of 28s-1 show event, the Medical Examinar must be rediffed at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:				anic Origin? (Sp Mexican, Puerto Specify: Whi	ecify Yes or No- Rican, etc.)		merican Indian, hite, etc. white
Medical I	Completed	15. Decedent's Edi (Specify only highest grad	ucation le completed) College (1-4or 5-)	Give kind of ife. DO NO		n ing most of work	ing	16b. Kind of Busines	ss/Industry
vent, Ina M	Be Con	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)		Mac	hinist	18			Stevens	on Co.
	Jo	Charles P. Byrne						e Moxle	,	
other traumatic		19a. Informant's Name/Relationship (T) Mary Virginia Byr		123	8 Glyr	ndon Av	, Baltin	ore, MD	City or Town, State	, Zip Code)
enportant: If Item any injury or othe once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Cometery, Loudon	rematory of Park	Name of or other place) Cem.	June8		20c.Location-City of Baltimore	or Town, State
any inj		21. Signature Funeral Service Lice 5	Man	me)	22. Name 3620	and Address of Wilkens	of Facility Lous S Ave.	don Parl	k Funeral e, MD 2122	Home 29
ician dical niner		23a. Parv. Enter the disease, or complete sheet, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a Myoc	ne death. Do no	136		ARC)			Approximate Interval Betwee Onset and Dec
should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of)						
ached for use as	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death	3 □Ectopic 5 □ Other				23d. Date of d Month	elivery Day Yea
uld be del	ed by P	Part II. Other significant conditions col	ntributing to death but		ne underlyin	g cause given ir	n Part I.		acco use contribute s 2 □ No 3 □ F	to the cause of dear
page 2 sho	Completed	COPO	92 THR.	1710				24a. Was ar autopsy perform	prior to death?	autopsy findings ava completion of caus
al director, page 2 st	To Be (25. Was case referred to medical examiner?	dospital:	2 ER/Outpa	atient 3			(Check only one		
- (6)	Certification:	27. Manner of Peath 1 Autural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day	Year) 28b. Tim Inju		28c. Injury at Work?			w injury occurred	
۵		4 Homicide determined	28e. Place of Injury building, etc.	(Specify)			ap carrier	City or Town,		
completely filled in	edical	29a. Certifier Certifying Physical Conections (Check only one)	sician: To the best of ner: On the basis of e and manner state	xamination and/o	eath occurre ir investigati	ed at the time, on, in my opinion	date and place, a on, death occurre	nd due to the car d at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
. 6	Me	29b. Signature and title of certifier				29c. License nu			d. Date signed (Mon	
com			1 1 2							

			4 101	epartment of Health and Mo Certificate of Death	ental Hygiene	2001 10001
	Physici /Medic		1. Decedent's Name (First, Middle, Last) AAP DA BAR BR 62 122		2. Date of Death Month Da	3. Time of Death
	Examir	ner	1925 GUILFORD AVE.	4b. City, Jown, or Location of Death ATTIMORE (av) If Under 1 Year If Under 24 Hrs.		c. County of Death
	Funeral Director		5. Social Security Number 214 44 5332 Output Control C	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9-15-194	9. Birthplace (State or Foreign Nountry) LAND
	death with the Maryland ms 23a or 28a-f show Lithual be ficilitied at	tor	10a. State 10b. County 10c. City, Town or SA	r Location UTIMORE		10d. Inside City Limits 1 M Yes 2 □ No
	ath with the Marylar 23a or 28a-f show	Funeral Director	10e. Street and Number 1925 GUILFORD AVE.	10f. Zip Code 2/2/8	10g. Cit	tizen of What Country? U.S.A.
336		by Fune		13. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F 1 Yes 2 No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
Maryland 21215-003	d within 72 hours after giene. ir than "naturel", or Ite Ine Medical Experine	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ecedent's Usual Occupation live kind of work done during most of workin e. DO NOT use retired) SUPERVISOR	ng	find of Business/Industry YLAND TRANS CENTER
/land 2	should be filed within ord Mental Hygiene marked other than armatic avent, Ins.M.	To Be Co	17. Father's Name (First, Middle, Lost)	18. Mother's Name	(First, Middle, Maiden	n Surname)
100	and 2 sho saith and i n 27 is me er traume			ailing Address (Street and Number or Rural	Route Number, City of BATIL	or Town, State, Zip Code) NUCLE MO 21218
imore,	Pages 1 ament of He ent: If item ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify)	crematory or other place) N	04 DWIN	ocation - City or Town, State IAS MILLS, MANY (AND
Balti	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service Licensee			REENE FUNERIL HIME NORE, MD 21212
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):	enter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
8760,	ate be executed hysicien and the burial-transit	dical Examine				
.O. Box 6	death certific e attending p id for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
rds, P	law requires that the de as been signed by the a 2 should be detached f			e underlying cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?
	The ate h page	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)
Division of Vital	Phy this ral d	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	e of 28c. Injury at 28		
DIVIS	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	8f. Location (Street an City or Town, State	nd Number or Rural Route Number, a)
	To the Hospitel or within 24 hours after To the Funerel Dire completely filled in b	edical	29a. Certifier (Check only one) 1 [Vertifying Physician: To the best of my knowledge, de 2 Medical Exeminer: On the basis of examination and/or and manner stated.	aath occurred at the time, date and place, ar r investigation, in my opinion, death occurred	nd due to the cause(s) d at the time, date and	and manner as stated. If place, and due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	29c. License number D79071		te signed (Month, Day, Year)
	5		30. Name and address of person who completed cause of death (Item 23a) (Type RANANDA KUTS HVAN MD 821	D29071 De. Print) W. EUTAW ST BA	ITI MORE	E MN 21201
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Souls		

State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Olivia Month > Day **Physician** eanette /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westwinstp proli 10501 6. Sex ente Months Days Hours Min. 0 ct. 20, Year) 913 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 212-38-4353 1□M 2X F 90 Mary and Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or Items 23s or 28s-f ehov any injury or other traumatic event, I'm Medical Examination in Item Patified at 1 XYes 2 □ No Director MD Carroll Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 113 N. Main St. Extd. 21791 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ YNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify þ 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School teacher Public school 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles L. Angell Mary E. Devilbiss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2086 Baltimore Blvd., Finksburg, MD 21048 Robert Alexander - nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State
4 Donation 5 Other (Specify) All County Cremation 6/7/2004 Sykesville, MD 21. Signature of Funeral Service Cense 22. Name and Address of Facility Hartzler Funeral Home 6 E. Broadway, Union Bridge, MD 21791 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician watio /Medical to (a as a consequence of): Examiner tugki Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit or Attanding Physician; The law requires that the death certificate be execute. the attending physician and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 200 1 Yes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? hasl autopsy performed certificate 20 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide determined within 24 hours after To the Funeral Direct Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) e q 29b. Signature and title of certifile 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)
JUN 1 0 2004 32. Registrar's Signature State Registrar

			For State O' Registrar	f Maryland / D		t of Health an		Reg. No.	4 18306
	Physici	an	1. Decedent's Name (First, Middle, Last) Doroth:	y Jean Bear	rry		2. Date of D Month		3. Time of Death
	/Medic Examin	- 11	ta. Facility Name (If not institution, give street and nur MARINER HEALT)	H of BEL A	IR Be	Town, or Location of C	Peath	4c. County of Dea	ath ORD
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. last birtl	hday) If Under Months	Days Hours	Vin. (Month, L	Day, Yeer)	rthplace (Stete or Foreign country)
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	he Man 28a-f sh culfied	Director	Maryland Harford		104 7:-	Bel Air		10g. Citizen of What C	1 ☐ Yes 2 ☑ No
	h with t	al Dir	10e. Street and Number 1501 Dundee Court		10f. Zip	21014		United St	,
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or flems 23e or 28a-f show surmatic svent, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, Giv	2√∑ No re	13. Was Decedif Yes, specific Yes	dent of Hispanic Origin cify Cuban, Mexican, P APANo Specify:	? (Specify Yes or Nuerto Rican, etc.)	14. Race - Am Black, Wh Specify:	erican Indian, ite, etc.
21215-0036	hin 72 hours a. an "natural", Wed cal Ex	Completed	15. Decedent's Education (Specify only highest grade completed)		Decedent's Usua (Give kind of wo life. DO NOT us	ork done during most of	working	16b. Kind of Busines	Vhites/Industry
	e filed withi al Hygiene. I other than	Com	Elementary/Secondary (0-12) College (1	-40r 5+)	Home	maker			Home
Maryland	s 1 and 2 should be filed f Health and Mental Hyg tem 27 is marked othe other traumatic svent,	To Be	17. Father's Name (First, Middle, Last) David R. Masincupp				la Mae Tv	veed	
Mary	12 should he and he and he rea	-	19a. Informant's Name/Relationship (Type, Print) Mrs. Cheryl McBride/Dat			(Street and Number o		ber, City or Town, State, Maryland	X
	is 1 and 2 of Health item 27 I		20a. Method of Disposition	20b. Place of	Disposition (Nar y, crematory or c	me of	Date Date	20c. Location - City o	21014 r Town, State
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from '4 ☐ Donation 5 ☐ Other (Specify)	State	vridge M	lem. Park 6	/8/2004	Dorsey,	Maryland
Ba	permi Depa Impo any iu	. 10	21. Signature of Funeral Service Licensee Standarus Mas	sey	Duda-R	ack Funera	l Home of Dundalk.	Dundalk, 1 Maryland 2	nc. 1222
	Physician		23a. Part1. Enter the disease, or complications that control shock, or heart failure. List only one cause on elimediate Cause (Final disease or condition	aused the death. Do n ach line. Sepsis	not enter the mod	de of dying, such as car	rdiac or respiratory	arrest,	Approximate Interval Between Opset and Death
	/Medical Examiner	0		Phalamor					Iwerk
11/	te be executed ysician and ie burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	or as a consequence of	of):				
TO7	5 S B	cai	d						
DOR O. Box	at the death certificat by the attending phy tached for use as th	Physician/Med	in the past 12 months?	come of pregnancy iirth 2 Fetal death ant at time of death own	3 □Ectopic po 5 □ Other (sp			23d. Date of de Month	elivery Day Year
CY rds, P	quires that in signed b uld be deta	by	Part II. Other significant conditions contributing to de	eath but not resulting in	the underlying o	cause given in Part I.		tobacco use contribute	to the cause of death? Probably 4 □Unknown
M R.R.	The law requires that the ate has been signed by the page 2 should be detache	Completed					24a. We aut per	opsy prior to death?	
3E/Vital	Physician: The this certificate har all director, page	Be	25. Was case referred to medical examiner? Hospital:			Other /	Death (Check only		
0	F F E	ıtlon: To	27. Manner of Death 28a. Date	of Injury 28b. T	tpatient 3 D0	28c. Injury at Work? 1 Yes 2 No	28d. Describe	sidence 6 Other (Sp. how injury occurred	ecify)
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be 28e. Place	of Injury - At home, far ng, etc. <i>(Specify)</i>	rm, street, factor	y, office		(Street and Number or Fown, State)	lural Route Number,
	To the Hospital or Atwithin 24 hours after of To the Funeral Direct completely filled in by	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the band man	best of my knowledge asis of examination and ner stated.	, death occurred d/or investigation	at the time, date and p n, in my opinion, death o	place, and due to the	e cause(s) and manner a a, date and place, and du	s stated. e to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier	10	29	c. License number		29d. Date signed (Mor	ith, Dey, Year)
	H		30. Name and address of person who completed caus	se of death (Item 23a) (Type, Print)	234025	1	June 5, 0	2004
			Scott Haswill 3 31. Date filed (Month, Day, Year) 32. R	2 Worth Legistrar's Signature	Avenu	(B1)	Air A	orygand	21014
	Sta Registi		JUN 1 0 2004 3	eners to	4 do	se fol			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Barry Month Year **Physician** mildred 19:00 pm 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner under Hospital Glen Burne Anne Hrundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7 Ane (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 049-03-8058 Director February 23, 1920 Connecticut Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Howard Columbia Be Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21045 U.S.A. 5464 Wild Lilac 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: White Specify 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mildred Foley William Quaile 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5464 Wild Lilac Columbia, Maryland 21045 Daughter Ms. Mary Ann Barry 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State All County Cremation Services, Inc. 06/07/2004 Sykesville, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Fluneral Service License 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 c mp. Thons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Four the disease shock, or heart failure. Immediate Cause (Final Physician disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 4□Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 2 No Certification: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifies Bell Land Clarkswell MD 21039 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 5005 Suran Abdo, MO

Registrar DHMH 17 Rev 1/2001

State

ortant: If itam 27 is marked other than "natural", or Items 23a or 28a-1 show injury or other traumatic event. The Moultal Examiner must be multipad at

and Mental Hygiene.

permit. Pages 1 and 2 should be f Department of Health and Mental F Important: If itam 27 is marked of

The law requires that the death certificate be executed

Hospital or Attending Physician:

after death. Diractor: After

within 24 hours a To the Funaral D

Division of Vital Records, P.O. Box 68760,

page 2 should be detached for use as the burial-transit

the attending physician and

been signed by

certificate has

filled in by the funeral director,

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) JUN 1 0 2004 32. Registrar's Signature

		1 - State Registrar	te of Maryland / Dep	partment of Health and Mertificate of Death	•	e 2004 1830
Physici /Medic Examin	al	Decedent's Name (First, Middle, Last) Geneva 4a Facility Name (If not institution, give street a.)		Vens 4b. City, Town, or Location of Death	June 1	ay Year 3. Time of Death 12.47 pm c. County of Death
Funeral Director	С.	Good Samavit. 5. Social Security Number 212-44-5584 Usual Residence of Decedent	7. Age (In yrs. last birthda)	Baltiwore If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, Yea 3-24-47	r) 9. Birthplace (State or Foreign Country)
he Maryland 8a-f show otified at	ector	10a. State 10b. County Md . NA	10c. City, Town or Balti	more	Lion	10d. Inside City Limits 1▼ Yes 2 □ No
th with ti 23e or 2	al Dir	32 N. Pulaski Street		10f. Zip Code 21223	10g. C	Citizen of What Country? USA
fore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If time 27 is marked other than "neturel; or items 23e or 28e-f show or other traumette event, the Medical Examinar must be notified at	by Funeral Director	1 Never Married 2 Married 1 It Y	s Decedent Ever in U.S. led Forces? Yes 2 XNo less, Give lar or Dates:	. Was Decedent of Hispanic Origin? (Sp. It Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
Maryland 21215-0036 nd 2 should be filed within 72 hours at this and Marial Hygiens. To its marked other than "neuturel; or traumette event, the Medical Exami	Completed	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) Col 10th grade	ege (1-40r 5+)	edent's Usual Occupation re kind of work done during most of work DO NOT use retired) Clerk	ing 16b.	Kind of Business/Industry Varies
yland out be filed Mental Hyger Hyger etter event,	To Be C	17. Father's Name (First, Middle, Last)	. Whetstor	ne Rhudine		Bookert
Mar nd 2 sho lith and 27 is m		19a. Informant's Name/Relationship (Type, Prid Monica L. Ellis Da		N. Pulaski Street,		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygene. Important: If item 27 is marked other than "naturel; or items sny injury or other traumetic event, the Medical Examination once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	from State 20b. Place of Disposer cometery, or Greenmo	ematory or other place) ount Cem. 6-9- 22. Name and Address of Facility	04 Ba Balt	ltimore, Md. imore, Md. 21202
Physician /Medical Examiner			that caused the death. Do not e e on each line. I e v () ue to (or as a consequence of):			Approximate Interval Between Onset and Death
ds, P.O. Box 68760, ires that the death certificate be executed signed by the attending physician and the detached for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	ue to (or as a consequence of): $\mathbb{R}^{e} \cap i \vee 0 \neq 0$	ay Souther S	4 400	horomy
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	by Physician/Medi	in the past 12 months?		□ Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
cords, P. w requires that been signed be should be detailed	ted by Pt	Part II. Other significant conditions contribution	g to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death? 2 No 3 Probably 4 Amknown
Division of Vital Records, for Attending Physician: The faw requires that after death. Director: After this certificate has been signed in by the funeral director, page 2 should be d	Completed	H(V			24a. Was an autopsy performed? 1 Yes 2 N	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
f Vit iysician iis certif directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital	1 ☐ Inpatient 2 ☐ ER/Outpatie	Other	me 5 Residence	6 Other (Specify)
Division of Vital Recontine Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2	Certification;	2 Accident investigation	Date of Injury (Month, Day Year) 28b. Time Injury	Work?" M 1 ☐ Yes 2 ☐ No	28d. Describe how inju	<u></u>
Division To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the	al Certiff	4 Homicide determined 286.	Place of Injury - At home, farm, s building, etc. (Specify) To the best of my knowledge, dea	ath occurred at the time, date and place,	City or Town, Sta	
the Hos in 24 h the Fur spletely	Medical	(Check only 2 Medical Examiner: On one) and	the basis of examination and/or manner stated.	investigation, in my opinion, death occurr	ed at the time, date ar	nd place, and due to the cause(s)
To To Coor	2	29b. Signature and title of certifier	MD	29c. License number D 60530	29d. D	ate signed (Month, Day, Year)
Sta	ite	30. Name and address of person who complete Vilou R . H = (+ M) 31. Date filed (Month, Day, Year)	d cause of death (Item 23a) (Type 8 2 1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	e four St, Suite	308, Ba	ltmore, MD 21201
Registr		HIN 1 0 2004	Maria Maria	Breek. 8		

DHMH 17 Rev 1/2001

State Registrar

Geneva Bowlens

		,	1 - State of Maryl	land / Depa <i>Cei</i>	artment of Health	h and Me		ene 2004	18310
	Physici	an	Decedent's Name (First, Middle, Last)	D	nale Tro	2	Date of Death Month 7	Day 2004 Pear	3. Time of Death
	/Medic	al	George 4a. Facility Name (If not institution, give street and number)	В	uck, Jr. 4b. City, Town, or Locati	ion of Death	0 /	4c. County of Death	4:43a M
	Examin	er	8909 Allenswood Rd.		Randalls			Baltimor	`e
	Funeral Director		5. Social Security Number 6. Sex. 1.2 M 2□ F 7. Age (In 49)	yrs. last birthday) Yrs.		der 24 Hrs. 8	Date of Birth (Month, Day, Y	9 Ridhal	ace (State or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c	: City, Town or Lo	ocation			10	0d. Inside City Limits
	Mary a-f sh	tor	Md. Baltimore	Randa	alllstown				1X Yes 2 □ No
	or 28	Funeral Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Coun	ry?
	sath v	eral	8909 Allenswood Rd. 11. Marital Status 12. Was Decedent Ever	in IIS 13 1	21133	Origin? (Speci	fy Yes or No-	USA 14. Race - America	an Indian
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, tra Madical Era: I at must be notified at	by Fun	1 Markal Status 1 Never Married 2 Married 3 Widowed 4 Divorced Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 ☐ Yes 2 X No Spec		can, etc.)	Black, White, e	itc.
5 0	72 ho 'natur	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during r	most of working	16	b. Kind of Business/Ind	ustry
21215-0036	within ane. than "	Completed by	Elementary/Secondary (0-12) College (1-4or 5+)		ne Improveme	nt		Varies	
о 2	Hygie other	Be Co	12th grade 17. Father's Name (First, Middle, Last)	1101			First, Middle, Ma		
ylan	2 should be f n and Mental H is marked of raumatic eve	To B	George Buck, S	Sr.	ī	Marlene	N	Medley	
	1 and 2 sho Health and tem 27 is ma		19a. Informant's Name/Relationship (Type, Print) Marlene Smith Mother		ng Address (Street and Nu. P Allenswood				^{Code)} 21133
Baltimore,			1 🔀 Burial 2 □ Cremation 3 □ Removal from State		natory or other place)	Dai	-	c. Location - City or To	
Ē	permit. Page Department of Important: If any injury or once.		` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	King Me	OM. PK. Name and Address of Fa	6-12-0		andallstown	
Ba	Depar Impo		I Slady wan	ا رو	March F.H. E	Cast	1101 E	imore, Md. . North Ave	
	2 11		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final)	death. Do not ent	er the mode of dying, such	h as cardiac or i	respiratory arrest	,	Approximate Interval Between Onset and Death
	rnysician /Medical		disease or condition resulting in death) Due to U ras a cor	d_Jmn	nunodefier	rcy 5	yndrov	nes	5 years
П	Examiner		Sequentially list conditions.			~			
_	led sit	ulner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	nsequence of):					
ノ	cate be executed oblysicien and the burial-transit	Examiner	that initiated events c c Due to (or as a cor	nsequence of):					
8760,	ate be nysicie he bur	dical	d			·			
9	entifica ling ph	/Med	IF FEMALE: 23c. If yes, outcome of pri	2000000					
O. Box	ne death certificate be executed the attending physicien and hed for use as the burial-transit	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1	Fetal death 3□	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	y Day Year
, 0	that the detected	y Ph	Part II. Other significant conditions contributing to death but no	t resulting in the u	nderlying cause given in Pa	art I.	23e. Did tobac	cco use contribute to the	e cause of death?
rds	w requires that s been signed t should be det	ed by	Mycobacterium arium i	utracell	mare		1 Tes	2 Proba	bly 4 □Unknown
Vital Records,	B 8 C	Completed					24a. Was an autopsy performe	prior to com	sy findings available apletion of cause of
E E		e Col	25. Was case referred to medical		96 D	Ness of Donah /	1□ Yes 2\	1 Yes	2□ No
	Physician: r this certifica ral director,	To B	examiner?	2 ER/Outpatien	Other		Check only one) 5 Desidend	se 6 □Other (Specify))
n of	ding Ph After th funeral		27. Manner of Death 1 MSNatural 5 ☐ Pending 28a. Date of Injury (Month, Day Yea	28b. Time of Injury	Work?		d. Describe how	injury occurred	
Division	Attending if death. ector: After by the fune	Icati	2 Accident investigation 3 Suicide 6 Could not be 280 Blood of Injury	At home farm etc	M 1 Yes 2		f Location (Stree	et and Number or Rural	Route Number
<u>≥</u>	al or Attendates after death	Certification:	4 Homicide determined building, etc. (S)	pecify)	eet, lactory, office		City or Town, S		, route realition,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one) (Check only one) 2 Medical Exeminer: On the basis of examination and manner stated.						
	To the within 2. To the complet	Me	29b. Signature and title of certifier		29c. License numb	oer	29d	. Date signed (Month, D	ay, Year)
)			Den R. Richardso	on, M	2 DOO 5	382	4 0	6-08-7	2004
	3		30. Name and address of person who completed cause of death					2	
	Sta	ite	1eri R. Richardson, MD 442. 31. Date filed (Month, Day, Year) 32. Registrar's S	G YOYK H Signature	eights . Ane	Back	e, no	41215	
	Registi		JUN 1 0 2004	in the	books.				

			State of Maryland / De	epartment of Health and Mei	ntal Hygiene	
		•		Certificate of Death	Reg. No. 2 0 0 L	18311
			Decedent's Name (First, Middle, Last)		Date of Death Month — Day Year	3. Time of Death
	Physicia /Medic	al	Joseph Abraham Ciomei		JUNE 7, 2004	1:00 p M
	Examin	er	4e. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dec	
	Funeral		Cherry Lane Nursing Center 5. Social Security Number 6. Sex. 7. Age (In yrs. last birth)	Laure L day) If Under 1 Year If Under 24 Hrs. 8.	Date of Birth 9. Bi	Georges rthplace (State or Foreign country))15tr1ct
	Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth: 579-09-0175 1 △ M 2 □ F 85 Yr	s. Months Days Hours Min.	Date of Birth (Month, Day, Year) JAN 11, 1919 of	Columbia
	and	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of the County 10c. City, Tow	or Location		10d. toside City Limits
	Maryl	to	Maryland Prince Georges	Bowie		1 ☐ Yes Ž No
	death with the Maryland me 23e or 28e-f ehow	Funeral Directo	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	ountry?
	ath wi	rai	12101 Faith Lane	20715	USA	
	iteme	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☒ Married 1 ☒ Yes 2 □ No	 Was Decedent of Hispanic Origin? (Specific If Yes, specify Cuban, Mexican, Puerto Richards) 	y Yes or No- an, etc.) 14. Race - Am Btack, Wh	ite, etc.
2-003p	urs af	þ	1 ☐ Never Married 2 ሺ Married 1 ሺ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 📉 No Specify:	Specify:	White
ဂ ဂ	d within 72 hours after death with the Marylar gene stran "naturel", or iteme 23e or 28e-1 show the Medical Examiner meat be molified at	Completed	15. Decedent's Education 16a. C (Specify only highest grade completed)	ecedent's Usuat Occupation Give kind of work done during most of working ife. DO NOT use retired)	16b. Kind of Business	s/Industry
7	within	dm	Elementary/Secondary (0-12) College (1-4or 5+)	ne. DO NOT use retired) Machinist	Federal	Government
2	T HAY	Be Co	17. Father's Name (First, Middle, Last)		First, Middle, Maiden Sumame)	00 / 02/12/10/10
land		To B	George Joseph Ciomei	Hattie 1	Elizabeth Koontz	
Mar)	s 1 and 2 should 1 Health and Mer Item 27 is marke other traumatic			Mailing Address (Street and Number or Rural R		Zip Code)
a) O	1 and Health em 27 ther t		20a Method of Disposition 20b. Place of D	Disposition (Name of Date	MD 20715 20c. Location - City o	r Town, State
Ď E	eg ° = 5		Cemetery,	crematory or other place) Crematory, Inc 06/08	/04 Baltimore,	MD
Baltimor	permit. Pa Departmen Important: any injury once.		21. Signature Fun ral Service Licensee	Cremation Society of	f Maryland, Inc.	
מ	89 5 8 8		Dawn F. McDonald	299 Frederick Road	Baltimore, MD 2	
			23a. Pert1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between Onset and Death
	Physician / /Medical		tmmediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of	warm mu	monia	Week
	Examiner		Chamair	Sornitive Julmo	mary resease	Several
	P %	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the interest of the control of th):		geans
	be executed sicien and burial-transit	Examiner	resulting in death) Last C. Due to (or as a consequence of):		-
/60		calE				
68	eath certificate attending phy I for use as the		IF FEMALE:			
X R R	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	3 Ectopic pregnancy	23d. Date of de Month	elivery Day Year
	the de y the a	ysic	1 Yes 2 No 9 Unknown	5 Other (specify)		
ב ב	The law requires that the death certifica tie has been signed by the attending ph tage 2 should be delached for use as th	by Physician/Med	Part II. Other significant conditions contributing to death but not resulting in	he underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?
ğ	v require been sig should b				1 Yes 2 No 3 F	Probably 4 Unknown
Vital Records,	e law r has be je 2 sh	Completed			autopsy prior to	utopsy findings available completion of cause of
a		e Col	25. Was case referred to medical	00 Plans of Davids	1 Yes 2 No 1 Ye	s 2 No
	ysicie is certi directo	O B	examiner? Hospital:	26. Place of Death (€ patient 3□ DOA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Sp	ecify)
Division of	ng Ph fter th ineral	Du: T	27. Manner of Death 1 X Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Inj	ne of 28c. Injury at 28c ury Work?	d. Describe how injury occurred	
SIO	tendi death. tor: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of thiury - At home, farm	M 1 Yes 2 No	Location (Street and Number or F	Qural Pouta Number
	after of Direct of in by	Certification:	4 Homicide determined building, etc. (Specify)	ii, stieet, lactory, office	City or Town, State)	Ida riddig rumber,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	edical C	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and	death occurred at the time, date and place, and	d due to the cause(s) and manner a	as stated.
	the H	Medi	one) and manner stated. 29b. Signature and title of certifler	29c. License number	29d. Date signed (Mor	
ļ	8 4 \$ 7		, story	12 721	June 80	2004
	4		30. Name and address of person who completed cause of death (ttem 23a)	sports Rowie Rd. St20	C 1 11.05. 30	2 22
			SYEL SADW 14333 Lawel	HOWIE KU, ST20	o THOKKY IN	11) 20/08
	Sta Registi		31. Date filed (Month, Day, Year) 1 JUN 1 0 2004 32. Registrar's Signature	spales		
			JUNT 0 FOOT V			

		1 - For Amend Item 2	State of Maryland 3a per Dr., G83	d / Department 2 ,06/10/04d Certificate	of Health and I hb of Death	Mental Hygier Reg. t	2004	18312
Physic /Med		1. Decedent's Name (First, Middle, Las	Cowans			2. Date of Death Month	Day Year O4	3. Time of Death
/ Exam Funera Director	ner	24 30 2137	Paryland Hospite	3 30 -	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Yes	Salting 9. Birth	no re City nplace (State or Foreign untry) MD
Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County		Town or Location BACTIMD	RE	1		10d. Inside City Limits 1 Yes 2 No
th with the 23a or 28	Funeral Director	10e. Street and Number 1311 N. STOCK	TON STREE	10f. Zip C	21217	10g. (Citizen of What Co.	A .
5-0036 72 hours after death with the Maryland naturel; or Items 23e or 28e-f show Meal Exprainer mant by notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		nt of Hispanic Origin? (S y Cuban, Mexican, Puert	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, White Specify:	
within with	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary, (0-12)	college (1-4or 5+)	life. DO NOT use	done during most of wor retired)	king 16b.	Kind of Business/I	
Maryland 2 d 2 should be filed tht and Mental Hygie 27 is marked other traumatic event, in	To Be C	17. Father's Name (First, Middle, Last) WALTER LEE	POWELL		LUCI		ULKN	
Mary and 2 sho lealth and m 27 is m		19a. Informant's Name/Relationship (1) MARVIN BUR	Rell	19b. Mailing Address (131 N. ST ace of Disposition (Name		TREET E	ALTO.	MD 21217
Baltimore, permit. Pages 1 a Department of Her mportant: If item nny injury or other once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signafure of Funeral Service Licen	Removal from State CO	metery, crematory or oth . ZION CE	er place) METERY 05/2	29/04 B		e, MD
Balt permit. Depart imports any inj		+ Vangh C		515 B	Address of Facility N.C. GREEN ALTIMORE I	NATIONAL P	IL SERVI	CES TO MD 21229 Approximate
Physician /Medica Examiner	er	23a. Part1. Enifer the disease, or composition in shock, or least failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Due to (or as a consequence to or as a con	ence of Agonal	Aspiration			Interval Between Onset and Death 7 hours
Box 68760, eath certificate be executed attending physician and for use as the buriat-transit	dical Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseque	ence of):				
. 0 00	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal o 4 □ Pregnant at time of dea	death 3 Ectopic pres			23d. Date of deli-	very Day Year
cords, P w requires that been signed b		Part II. Other significant conditions of Diabete	entributing to death but not resul	ting in the underlying cau	ise given in Part I.			the cause of death?
Records, P.O The law requires that the ate has been signed by the page 2 should be detached.	Completed	Right leg	amputation			24a. Was an autopsy performed?	prior to e death?	opsy findings available ompletion of cause of
of Vital Physicien: 1 ribis certificat	To Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 □Inpatient 2 ☑E	R/Outpatient 3 DOA	Other	th (Check only one) ome 5 \subseteq Residence	6 □Other (Spec	ify)
Division of Vital Rec To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has compiletely tilled in by the funeral director, page 2.	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	М	c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred	
DIVI		4 ☐ Homicide determined	building, etc. (Specify)			28f. Location (Street: City or Town, Sta	te)	
the Hosp in 24 hou the Fune ipletely ti	Medical	(Check only 2 Medical Examone)	valcian: To the best of my know iner: On the basis of examination and manner stated.	on and/or investigation, in	n my opinion, death occur	red at the time, date a	nd place, and due	to the cause(s)
To t To t com	Σ	29b. Signature and title of certifier	2. My	M.D. 404	License number /176435 <i>I</i> 1379	29d. D	eate signed (Month)	Day, Year)
(1)		30. Name and address of person who charts E. II			cet, Baltin	ore Md		•
S	ate	31. Date filed Morth, Day, Year 4	32. Registrar's Signatu		/	,		

		1 - For State Registrar	State of Ma	arytanu / D	Certifica	te of L	Death		1109.110.	2004	1831
Physici	an	Decedent's Name (First, Middle, Last						2. Date of E Month 05	Dav		3. Time of Death
/Medic	cal	Anthony V. Casse: 4a. Facility Name (If not institution, give			4h Cih	. Tourn or	L costion of Do		30′	2004 County of Death	11:50 P
Examin	ner	1303 Mill Creek	· ·			allst	Location of De	atn		Harford	
uneral		5. Social Security Number 6. S	ex 7. Age	e (In yrs. last birti	nday) If Und	er 1 Year	If Under 24 H			9. Birtho	lace (State or Fore
rector		217-03-6336	X M 2□F	94	rs. Months	Days	Hours M	10/28	/1909	Ita	
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1 sho	ō	MD Harford	٦ .	Falls							1 ☐ Yes 2X
7 28a-	Director	10e. Street and Number		20111		ip Code			10g. Citiz	zen of What Cour	ntry?
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ems	ıner	11. Marital Status	12. Was Decedent ! Armed Forces?		13. Was Dec	edent of Hi	spanic Origin? n, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	10-	14. Race - Americ Black, White,	
rthan "natural", or tlems 23a or 28a-1 show It's Musical Examinal redail be notified at	by-Funeral	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 N If Yes, Give	lo	1 ☐ Yes		Specify:			Specify:	
al Ex	ed b	15. Decedent's Ed	Year or Dates:	16a.	Decedent's Us	ual Occupa	ation		16h Kir	nd of Business/Inc	
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ovent, I	Be	17. Father's Name (First, Middle, Last)					18. Mother's N	lame (First, Midd	le, Maiden	Sumame)	
marked o	ဥ	Joseph Casseri						ıtina Cer			
8 2		19a. Informant's Name/Relationship (Town, State, Zip	
item 27 other tra		Eva B. Hart (dan 20a. Method of Disposition	ugnter)					Date		Marylar Cation - City or To	
		1 XBurial 2 ☐ Cremation 3 ☐		20b. Place of cemetery Most Ho				03/2004		altimore	
구는	ŀ	' 4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Licenter)		PIOSC IIC			1			Funeral	
any ir		1E AX	2221							e, Maryla	
hysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as:	a consequence o	5	7					-
ned by the attending phys detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant at 9☐ Unknown	2 Fetal death time of death	3 Ectopic 5 Other (s	pecify)	on in Part I	23a Did		3d. Date of delive Month	Day Year
en sigr	ted by	Tarrin Stron Significant Sensitions			the underlying	Cause give				No 3 □ Prob	
ate has page 2	e Completed							per 1□ Yes	opsy formed? 2010	24b. Were autop prior to con death? 1 ☐ Yes	psy findings available in pletion of cause
5 5	o B	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2□ER/Out	patient 3 🗆 D	OA Othe		eath (Check only	Q:	☐Other (Specify	d
	H- +	27. Manner of Death	28a. Date of Injur	y 28b. Ti		28c. Injury Work		28d. Describe	_		′)
shis al dir	0	2 ☐ Accident 5 ☐ Pending investigation	(Month, Day	rear) In	jury M		r res 2 □ No				
After this uneral dir	m m	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injubuilding, etc	Iry - At home, fan :. (Specify)	m, street, facto	ry, office			(Street and own, State)	Number or Rura	l Route Number,
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Director: After this In by the funeral di	dical Certification:	29a. Certifier Certifying Ph	ysician: To the best on niner: On the basis of and manner sta	examination and	death occurred for investigation	d at the tim	e, date and pla pinion, death oc	ce, and due to the curred at the time	e cause(s) a , date and	and manner as st place, and due to	ated. the cause(s)
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ē,	is 1 and 2 of Health item 27 other tra		20a. Method of Dispo				Place of Dispo	sition (Nam	ne of ther place	9)	Da	ate	20c. Lo	ocation - (City or To	wn, State	
Ē	Pages nent of nnt: If it ury or o			JCremation 3 ∟ 5 □ Other (Specif]Removal from Sta y)	are I	surrect		-		5/07/	2004	Clin	ton,	Mar	yland	
Baltimore,	permit. Pages Department of H Important: If its any injury or of		21. Signature of Fun	neral Service Licer	ee/		22	2. Name and	d Addres	s of Facility	v (alas	Funer	al H	lome	РΔ		
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Вох	ath cattend	ian/	23b. Was decedent in the past 12 r		23c. If yes, outco 1 Live birth 4 Pregnan	n 2 🗌 Feta	al death 3	Ectopic pre						23d. Date Mon		ory Day Yea	ar.
o.	it the de by the a tached	ysic	1 □ Yes 2 □ 9 □ Unknown]No	9 Unknow		16atii 5 [1 Other (spe	BGIIY)								
σ.	tha ded		Part II. Other signifi	cant conditions o	ontributing to deat	h but not re	sulting in the u	nderlying ca	ause give	n in Part I.		23e. Did t	obacco u	use contri	bute to th	e cause of deat	th?
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7	Physician: r this certific ral director,	ဥ	1 ☐ Yes 2 X ☐X		Hospital: 1 ☐ Inp		ER/Outpatier		100000	4 🗆 1901	-	e XXResi				/)	
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C			ysician: To the bas niner: On the bas and manne	s of examin											
	To the within 2 To the complet	Me	29b. Signature and I	title of certifier					. License				29d. Da	te signed	(Month,	Day, Year)	
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	In		30. Name and addre				т 23а) (Туре,		-								
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	Sta Registi			1 0 2004	Sent	مهمر	G.	Loan	12.6								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1:30A MICHAEL ANTHONY CARROLL JUNE 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER LA PLATA CHARLES If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) DEC. 9, 1953 Birthplace (State or Foreign
Country) **Funeral** 1**∑** M 2□ F Director 217-66-2212 50 WASHINGTON, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-1 show 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examinar is dait be notified at 1 ☐ Yes 2 ☑ No Director CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15470 SORREL RIDGE LANE 20601 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 250 Married Maryland 21215-0036 1 ☐ Yes 2XXINo þ Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. FAIRFAX COUNTY Elementary/Secondary (0-12) College (1-4or 5+) FIRE PROTECTION SPECIALIST PUBLIC SCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mental EDWARD JOSEPH CARROLL HELEN ROSEMARY RAULERSON and is 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 is KAREN A. CARROLL / WIFE 15470 SORREL RIDGE LANE WALDORF, MD 20601 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ö ™Burial 2 Cremation 3 Removal from State Department Important: I any injury o * 4 ☐ Donation 5 ☐ Other (Specify) TRINITY MEM. GRDNS. JUNE 8,2004 WALDORF, MARYLAND permit. 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityBRINSFIELD-ECHOLS FUNL.HME., P.A. Ste 30195 THREE NOTCH RD. CHARLOTTE HALL, M00641 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit and Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE 950 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Live birth jo in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f I ☐ Yes 2 ☐ No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 200 No Division of Vital 1 Yes 2 No 1 🗌 Yes 25. Was case eferred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: after death.

Director: After After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospitel of within 24 hours all To the Funeral D 29a. Certifier 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature at 29d. Date signed (Month, Day, Year) TONSALNES M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death June 7, **Physician** 2004 11:42 a.m Antonio A. Cavallio /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner Manor Care Rossville Rosedale Baltimore If Undar 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 01/14/1926 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1X M 2□ F Yrs 212 20 5158 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or items 23s or 28s-1 showeny injury or other treumstic event, the Medical Examinar must be notified at 1 ☐ Yes 2 XNo MD Harford Bel Air **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21015 201 M. Burkwood Ct. USA 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: White Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Self-employed Elementary/Secondary (0-12) College (1-4or 5+) Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Joseph Cavallio Rosa Sciancalepore 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 9432 Bellhall Dr. Nottingham, Maryland 21236 DAUGHTER Joanne Fischer 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Parial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery 06/11/04 Baltimore, MD. 22. Name and Address of Facility Cvach/Rosedale Funeral Home 21. Signatur of Funeral Service Licensee >1211 Chesaco Avenue Rosedale Maryland 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical ENCEPHARO PASTY Examiner DATE Completed by Physician/Medical Examiner HERMOCELLING PARCINOMA Hospital or Attending Physicien: The law requires thet the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other aignificant conditiona contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown CORDNERY ARTERY DISENSE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Tes 2 -Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 1 Yes 2 → No 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. versi Director: A investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours e To the Funeral C 🖊 Certifying Phyaiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DS(306 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 9106 PHLADERINA RD, SUITE 200, BALTO, NO 21237 ·H.001E Mb 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Amend Item 23a per Dr., G834, October Cate hof Death Reg. No. 2 U U 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** DEISE 7,20 am ALFRED DAMUEL Oth 200 lune /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Pose Baltimore Franklin Square Hospital Center 9. Birthplace (State or Foreign Country)

ARYLAND 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days 1**25**M 2□ F Hours Min. 216.20.0477 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count 28a-f show other traumatic evant, the Medical Examiner must be notified at BALTIMORE MARYLAND 1 ☐ Yes 2 No BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 PPERLANDING ROAD S.A 21221 23a should ba filed within 72 hours after death nd Mental Hygiene. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Dres 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married ö 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 □ Divorced and Mental Hygiene. Is marked other than "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) VAIL CARRIER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MILES 2 Lettini. Pagas 1 and 2 sho.
Department of Health Pimportant: if there any injury or an 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RD, BALTIMORE, MD 21221 JCHARD 20b. Place of Disposition (Name of crematory crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State EMPARK 6/12/04 PARKVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Senses 22. Name and Address of Facility EVANS CHAPEL OF MEMORIES RD, PARKVILLE, MD 21234 HARFORD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonia **Physician** then mone disease or condition resulting in death) 2 weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law raquires that the death certificate be axecuted nding physician and use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed certificate has been ostructive Pulmonary Disease 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? Division of Vital 1 Yes 1 Tyes or Attanding Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28c. Injury at Work? Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury Natural s after dea. 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Physician 00024303 June 10, 200 dress of person who completed cause of death (Item 23a) (Type, Print) Square Drive Baltimore MD. 21237 ah 9000 Franklin 32 Registrar's Signature Registrar

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			State of Maryland / Depa State Registrar Cer	tificate of Death	Reg.	2004	8319
	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year 3. Tir	ne of Death
	/Medic		Mary Ellen Deal				45P M
	Examin	er	4a. Facility Name (If not institution, give street and number) 816 Chumleigh Road	4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, Ye OCTODEY 25,	9. Birthplace (St Country) Mary I an	ate o <i>r Foreign</i> d
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	uth with the Maryla 23a or 28a-f shoust be notified at	I Dire	10e. Street and Number 816 Chumleigh Road	10f. Zip Code 21212	10g.	Citizen of What Country? USA	
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N/V	uted 3 ansit	Examiner	Sequentially list conditions, if any, leading to immediate Cause Extra Underlying Cause (Disease or Injury that initialed events				
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م م	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Medi		Ectopic pregnancy Other (specify)		Month Day	Year
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2	nding Ph th. : After th e funeral	atlon:	27. Manner of Death 1 Atural 5 Pending (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	
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_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director.		29a. Certifier (Check only Medicel Exeminer: On the basis of examination and/or inv	e occurred at the time, date and place, restigation, in my opinion, death occurr	and due to the cause ed at the time, date	o(s) and manner as stated. and place, and due to the cau	use(s)
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	10		30. Name and address of person who completed cause of death (Item 23a) (Type, E. TSO MD Richer Harrise 838	Print) N. Eutaw St B	altinos	MD 2001	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	rals	~11110016		
	Regist	rar	11 1 1 2004 Signer	vers			

		1. Decedent's Name (First, Middle, La.				Deam	2. Date of De Month	Reg. No. ath 06/08	3/04	3. Time of Death
Physici /Medic			Michael Cli	nton Doug	las		Month 3 L	NE 217	Year 2004	4:45 FM
Examin		4a. Facility Name (If not institution, giv Saint Joseph		Center	4b. City, Town, or	Tows		4c. Cou	nty of Death Balt	imore
Funeral Director		5. Social Security Number 6. S 216-50-6023	ex 7. Age	(In yrs. last birthday) 57 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da May 20	y, Year)	_	place (State or Foreign ntry) ennsylvania
and and	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation		 -		-	10d. Inside City Limits
Mary a-f sho	tor	Maryland H	loward		_ E	Ilicott City				1 □ Yes 2 No
with the 3a or 28a	Il Direc	10e. Street and Number 9234 Marydell Rd.			10f. Zip Code	21042		10g. Citizen	of What Cou U.S	
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Modical Examination ust be notified at	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E- Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	10115	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		Race - Ameri Black, White, city:	
d within 72 h gione. Ir than "natu	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+ 2	(Give	lent's Usual Occup kind of work done o DO NOT use retired Air Tra	during most of wor		16b. Kind o	Business/In	ndustry rline
ould be filed Mental Hygi arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last Richard C) Clinton Douglas			18. Mother's Nar		, _{Maiden Surr} s Patricia		
d 2 should I th and Men 7 Is marke traumatic	μ.	19a. Informant's Name/Relationship (**		g Address (Street a			-	-	Code)
Page nent o ant: If ury or		20a. Method of Disposition 1 Burial 2 Cremation 3 5 4 Donation 5 Other (Specia	Removal from State	20b. Place of Dispo-	natory or other plac		Date 6/09/2004		n - City or To ykesville	own, State , Maryland
permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Lio	LUL MOL	293	Name and Address Slack Slack 3871 C	ss of Facility Funeral Hom Old Columbia	ne, P.A. a Pike Ellico	ott City, M	D 21043	
Physician /Medical		23a. Part 1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aCEREBR	OVASCULA			or respiratory a	rrest,		Approximate Interval Between Onset and Death 1 WEEK
Examiner			ACUTE	consequence of): AORTIC D	ISSECTI	ON				1 WEEK
rcate be executed physician and sthe burial-transit	dical Examiner	Sociamitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
The law requires that the death certificat the has been signed by the attending phy tage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	Petal death 3	Ectopic pregnancy	,			Date of deliving Month	ery Day Year
quires that n signed by	þ	Part II. Other significant conditions	contributing to death bu	t not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did t	× 1		he cause of death? bably 4 □Unknown
sician: The law requir s certificate has been si lirector, page 2 should I	Completed						24a. Was autoj perfo 1 🗆 Yes		b. Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of
sician certifii rector,	Be	25. Was case referred to medical examiner?	Hospital:		Oth	or	ath (Check only o		211 . (0	, ,
ding Physician: The n. After this certificate hi funeral director, page	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 Manpatien 28a. Date of Injury (Month, Day	28b. Time of	28c. Injun Wor		lome 5 ☐ Resi 28d. Describe			9/
or Atten after deat Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	oe Goo Bloom of Injur	ry - At home, farm, stre (Specify)	eet, factory, office		28f. Location (City or To		mber or Rura	al Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	edical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of and manner state	f my knowledge, death examination and/or inved.	occurred at the ting restigation, in my o	ne, date and place pinion, death occu	, and due to the irred at the time,	cause(s) and date and plac	manner as s e, and due t	stated. o the cause(s)
To the within To the Somple	Med	29b. Signature and title of certifier		ren'	29c. Licens	e number		29d. Date sig		
		> flul	5 asp		D 3	8655		JUNE	8,20	204
di		30. Name and address of person who		ath (Item 23a) (Type,		E TOWSO	N. MAR	YLAND	2120	4
St.	ite	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	la de					

			Please Type or Print in Blac State of Maryland / I					•	le.
			1 - State Registrar	•	rtificate of			Reg. No. 20 (18321
	Physici /Medic		1. Decedent's Name (First, Middle, Last) CHARLES J. EBERT, SR.				2. Date of De Month	Day 20	Year 645 A M
1	Examin	er	4a. Facility Name (If not institution, give street and number)			or Location of Death		4c. County of	
			NORTH ARUNDEL HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last bi	rthday)	GLEN If Under 1 Year	BURNIE	8 Date of Birt		ARUNDEL D. Birthplace (State or Foreign
6	Funeral Director		217 - 40 - 3511	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da 2/26/	Y Year) 42 M.	Country) ARYLAND
	show	or.	10a. State 10b. County 10c. City, Tow						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-1	rect	MD ANNE ARUNDEL 10e. Street and Number	P	ASADENA 10f. Zip Code	1		10g. Citizen of Wh	
	3a or	Funeral Director	1545 FAIRVIEW BEACH ROAD		211	22		USA	at obanny.
	ms 2	nera	11. Marital Status 12. Was Decedent Ever in U.S.	13.	Was Decedent of H	Hispanic Origin? (Spe	cify Yes or No	14. Race -	American Indian,
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or liems 23a or 28e-1 show event, the Medical Exate her chief be invilled at	by	Armed Forces? 1 Never Married 2 Narried 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:		1 Yes, specify Cub 1 ☐ Yes 2 🗷 No	an', Mexican', Puerto Specify:	Hican, etc.)	Specify:	White, etc. WHITE
2-0	72 ho	eted	15. Decedent's Education 16a (Specify only highest grade completed)	. Dece	dent's Usual Occup	oation during most of worki	na	16b. Kind of Busin	ness/Industry
21	within ene. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retire	d)			
	e filed within al Hygiene. other than vent, the Me		6 () '	LÜB	E BENDE	18. Mother's Name	/First Middle	MACHIN	E SHOP
and		Be c	BENJAMIN EBERT				(AMIEC)		
Maryland	should be nd Mental marked o	ပို		o. Mailir	ng Address (Street	and Number or Rura			ate, Zip Code)
	nd 2 alth a 27 is		DIANA EBERT / DAUGHTER 8	17	S. ROBI	NSON ST.	BALT	IMORE, I	MD. 21224
ore,	es 1 a of Hea fitem r othe				sition (Name of matory or other place		ate	20c. Location - Ci	ty or Town, State
Ë	Pagiment		`4 □Donation 5 □ Other (Specify) BAYV	IEW	CREMAT	ORY 6/10)/04	BALTIMO	RE, MD.
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Licensee	1		rskir Funi			
-	402 60	TI Y	23a Part Enterthe disease or complications that caused the death. Do			ET ST. E			. 21224 Approximate
			23a. Part1. Enter(the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	1000	- 0-). A A = A	(1	7	Interval Between Onset and Death
)	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence	000	REST	(KHOK)	1000	ure	5 Days
	Examiner			0.7.					
	p H	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	of):					
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events c	of).					
60,	be ex ician burial	al E	Due to (or as a consequence	or).					
687	death certificate t attending physi of for use as the t		d						
Box	death certificate e attending phys d for use as the	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		3E			23d. Date of	of delivery
	ie deatl the atte	Physician/Medic	in the past 12 months? 1 Ves 2 No 9 Unknown		Ectopic pregnancy Other (specify)	/		Month	Day Year
P.O.	ac ac	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death bot not resulting in	- th		ran in Cont I	220 Did to	bassa was southb	ite to the cause of death?
ds,	w requires that been signed is should be det	d by	WERNOCKES PSYCH	k)()	Cause giv	enin raiti.			Probably 4 Dunknown
Records,	law requires as been sign 2 should be	iete	Al calodic lines	n'Co	050		24a. Was		re autopsy findings available
Re	has has	Completed	Paral Gilme D	1~	10 - 1000	2. 10/	autop	sy prio med? dea	r to completion of cause of th?
Vital	ician: Th	BeC	25. Was case referred to medical	3e"	IOW BUCK	26. Place of Death		-	Yes 2,2 No
of V	di S	ToE	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou	itpatien	t 3 DOA Oth	er: 4 Nursing Hor	ne 5 Resid	ence 6 Other	(Specify)
0 0				Time of njury	Wor	'K?	8d. Describe h	ow injury occurred	
isio	Attending or death. ector: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be	ren ete		Yes 2 □No	19f Location (C	trant and bloombac	Description of the second
Division	in Sir fe	Certification;	4 Homicide determined building, etc. (Specify)			11/2	City or Tow	n, State)	or Rural Route Number,
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated.	e, death id/or inv	occurred at the ting restigation, in my o	me, date and place, a pinion, death occurre	and due to the d ad at the time, d	ause(s) and manne late and place, and	er as stated. I due to the cause(s)
	withi To t	Σ	29b. Signature and title of confiler		29a Licens	e number	2	9d. Date signed (A	fonth, Day, Year)
-			Yast no)	D &	1000		June o	6,2004
	2		30. Name and address of person who completed cause of death (Item 23a) NABIL BADRO 8109 ReTClerk	Hu.	Print) PASA	DENA T	ARYL	AND Z	1/22
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature 33.	,	sports				

		For 1 _ State	Please I	State of Ma	ryland / [nt of Hea	alth and N	dental Hygi	ene	04 18322
		Registrar	(F) - 1 44 1 H - 2 - 1	1		Certifica	le oi De	aui	2. Date of Death		3. Time of Death
	sician edical	Honry	Robert Fe						Month	8ª 200	3:15 P. M.
	niner	4	f not institution, give	street and number)		4b. Cit	y, Town, or Lo	cation of Death		4c. County of	Deeth
			Arundel H				len Bu		lan (Bin		Arundel
Funer Direct		5. Social Security N 034-26-6	5155 X	x 7. Age	(In yrs. last bir	Yrs. Months		Hours Min.	8. Date of Birth (Month, Day, Mar 2,	Year) 1935	3. Birthplace (State or Foreign Country) MA
pu »		Usual Residence of	Decedent 10b. County		10c. City, Town	or Location					10d. Inside City Limits
aryla	1		1								1 ☐ Yes 2 X No
the N	Director	MD 10e, Street and Nu	Anne Ar	undel	Sev		ip Code		10	g. Citizen of Wh	at Country?
with a or	2					101.2					
eath	6.0	8166 S	Silo Road	12. Was Decedent E	ver in U.S.	13. Was Dec	2114		ecify Yes or No- Rican, etc.)	14. Race	American Indian,
CLIZIS 15-UUSO filed within 72 hours after death with the Maryland Hygiene wither than "netural", or Items 23a or 28a-f show mit, the Mycical Espains from the multified at	by Funeral		ied 2 Married	Armed Forces? 1 → Yes 2 □ N If Yes, Give Year or Dates:				Mexican, Puerto Specity:	Rićan, etc.)	Specify:	White, etc. White
P Pon R	Pa		15. Decedent's Edu			Decedent's Us	ual Occupatio	on	1	6b. Kind of Busi	
C Z uin Z	Completed	(Spec	ify only highest grad	le completed) College (1-4or 5		(Give kind of w life. DO NOT	vork done duri use retired)	ing most of work	ing		
laryland Z1Z13-UU30 2 should be filed within 72 hours at and Mental Hygiene is marked other than "netural; or aumatic event, the Maricel Exam	8	Elementary/3eco	sidary (0°12)	2	,	Man	ager			Dept. c	f Defense
othe	8		(First, Middle, Last)				18	3. Mother's Nam	e (First, Middle, M	laiden Sumame)	5 STR 12
Maryland Id 2 should be file th and Mental Hy 7 is marked oth traumatic event	L C		3. Fenech					Doroth	y Frances	McWhir	k
aryla should I and Meni s marks			ame/Relationship (T)	ype, Print)	19b	Mailing Addre	ss (Street and		ral Route Number,		
# 43 B		Doroth	ny Mohnask	y / daugh	ter	8166 S	ilo Roa	ad Sev	ern, Mary	land 21	144
Baltimore, I permit. Pages 1 and Department of Heali Importent: If item 2 any injury or other		20a. Method of Dis	position		20b. Place of cemeter	Disposition (Nry, crematory of	ame of other place)	1		0c. Location - C	ity or Town, State
Page Nent of Int: If			☐ Cremation 3 ☐ F 5 ☐ Other (Specify)			and Vet			e 11, 004	Crownsv	ille, MD
mit.	#	21. Signature of Fu	ineral Service Licens	500	and the second	The Salary of	and Address o	of Facility			1 Home, P.A.
B F F F	g	> 77/a	rh R. Va	neura)	101357	1 Se	cond A		Glen Bur		
		23a. Part1. Enter I	he disease, or comp	lications that caused ne cause on each lin	the death. Do						Approximate Interval Between
Physicia	40	Immediate Cause	(Final	GALITE	- Tond	1 1	0	٥			Onset and Death
/Medic		disease or condition resulting in death)		a. Due to (or as a	a consequence	of):	O I				
Examin	er			Colo	Versila	0 +	ister	a_			
	ةِ ا	Sequentially list co	enditions, nmediate	Due to (or as a	consequence	on:	, ^	Name of the last			
BOX 68/6U, eath certificate be executed attending physician and for use as the burial-transit	Fyaminer	cause. Enter Unde Cause (Disease or that initiated events	injury	· ms	71 nu	Anti	No				
6U, be executed ician and burial-transit	L,		Last	Due to (or as	consequence	of).	- C.F.				
te be e ysician	a		•	d							
tifical	Pag	15 55 111 5									
Hecords, P.O. Box 68/ The law requires that the death certificate attents been signed by the attending physace 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was deceder	it pregnant	23c. If yes, outcome		3 □Ectopic	pregnancy			23d. Date	
deat deat	100	in the past 12 1 🗆 Yes 2	□No	4☐Pregnant at 9☐ Unknown		5 Other (Mont	n Day Year
D. D D at the d by th etache	, d	9 ☐ Unknowr	1	3LI OTIKITOWIT							
S, the set the gned be de	2	Part II. Other signi	ficant conditions co	intributing to death be	ut not resulting i	n the underlying	j cause given i	in Part I.			ute to the cause of death?
Cord * require been si	2					-			1 Yes	s 2 □ No 3	Probably 4 Unknown
VITAI RECONDS, sicien: The law requires t certificate has been signe rector, page 2 should be o	Completed								24a. Was an autopsy	24b. We	ere autopsy findings available or to completion of cause of
He The lav	, 8								perform	ed? de	ath?
Vital F vician: Th certificate rector, pag	9	25. Was case refe	rred to medical				2	6. Place of Dea	th (Check only one	<u> </u>	
	a	1 ☐ Yes 2 🗸	No	Hospital: 1 X npatie	nt 2 ER/Ot	utpatient 3 1	DOA Other:	4 🗌 Nursing H	ome 5 🗆 Resider	nce 6 Other	(Specify)
g P O				28a. ate of Injur	y 28b.	Time of njury	28c. Injury at Work?		28d. Describe how	w injury occurred	i
ath. R.: Aft	1	1 Natural 2 Accident	5 Pending investigation			M		s 2□No			
DIVISION OF I or Attending Physatter death. Director: After this lin by the funeral dii	ertification.	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injubulding, etc		arm, street, fact	ory, office		28f. Location (Str. City or Town,	eet and Number State)	or Rural Route Number,
DIVISION OF VITAL HE To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Madical			ysician: To the best of iner: On the basis of and manner sta	examination an						ner as stated. d due to the cause(s)
o the ithin o the	N	29b. Signature and	title of certifier			2	9c. License n	umber	29	d. Date signed (Month, Day, Year)
⊢≯⊨ŏ)	A	E Carl	1/1	۸.		N12	977	7	- 1.4 a = (1)	8 PATOLA
~	0	20 Name and add	res of person who a	completed cause of d	eath (Itom 22a)	(Type Print)		1-11		mu	0 2007
1)	Canida 4	DALTALIA	AAA . Zhi	1. 1.	A I	Rive	Mon	Rume	nn	21061
	State	31. Date filed (Mor	nth, Day, Year)	32. Registra	ar's Signature	MW 30		(Charles	J	, - 10	
Red	otate istrai	,		004	ere H	Souch	2				

DHMH 17 Rev 1/2001

Fenech Henry

			For State	State of Marylan		artment of H		•	•) [.	18323
			Registrar 1. Decedent's Name (First, Middle, Last)	3	Ce	rtificate of l	Death	2. Date of Dea	Reg. No.		10020
H	Physici		MADIA A.E		IRL	JU		Month U 4 C	Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give				r Location of Death		4c. County	of Death	
			Augsburg Lutheran			Pikesvi	111e		Baltim	ore	
	Funeral		5. Social Security Number 6. Sec	M 2Û √	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Day			ice (State or Foreign
	Director		214-12-8227 Usual Residence of Decedent	86	115.			Oct. 8,	1917	Mary1	and
	ylano how		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				100	d. Inside City Limits
	e Ma	ctor	MD Baltimore	Pik	esvill	e					1 ☐ Yes 2 ☐ No
	72 hours after death with the Maryland natural, or Items 23a or 28e-f show diseal Examinative matter motified at	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Countr	y?
	eath v	era	6811 Campfield Rd	Was Decedent Ever in U	C 12	21207	innania Orinina (Sa	- Van av Na	USA	- Americar	- Indian
(0	r Item	E.	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2-√∑ No	.3.	Was Decedent of Hi f Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)		k, White, et	
21215-0036	72 hours after dea "natural", or Items	Ď	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2— No	Specify: wh	ite	Specify:	whit	e
5-0	72 hc	Completed by	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	dent's Usual Occupa	during most of work	king	16b. Kind of Bus	iness/Indu	istry
121	within ene. than "	du	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	1)				
	filed Hygi ther		12th 17. Father's Name (First, Middle, Last)		Homem	aker	18. Mother's Nam	e (First, Middle,		ome	
<u>a</u>	should be nd Mental marked o matic eve	To Be	Theodore S. J. Sc	hlueter			Lil1	ian Emma	Snyder		
Maryland	s 1 and 2 should f Health and Men item 27 le marke other traumatic		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailir	ng Address (Street a				State, Zip C	code)
	1 and 3 Health sem 27 sther tra		Cheryl Cox- daugh	ter		Foxborou					
ŏ	0 0		20a. Method of Disposition 1 ☐ Burial 2.☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify)	TOTTIONAL IT OFFI STATE		sition (Name of Parrix or other place		04	Baltimo		n, State
Baltimore,	permit. Pag Department Important: I any injury o		* 4 □ Donation □ 5 □ Other (Specify) 21. Signature of Funeral Service License			Cremator Name and Addres					
Ba	Depri Impo		Kim Ack	Panne		20 Wilken					me
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the deat						A	Approximate nterval Between
	Pnysician		Immediate Cause (Final disease or condition	Athero	cle	robic (sodio	usscu	la D		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):						
	- Xammor	Į.	Sequentially list conditions,	Due to (or as a conseq	uence of):					_	
	uted 1 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	240 (0) (0) 42 4 50 (0)	201100 017.						
oʻ	exect an and rial-tra		resulting in death) Last	Due to (or as a conseq	uence of):						
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical		d							
Ø	nding pluse as t	Med	IF FEMALE:	10. 16	212.00						
Box	eath certifi attending for use as	clan	in the past 12 months?	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery	ay Year
o.	t the de by the tached	Jysk	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown		Other (specify)					
٥,	es that igned b be deta	by Pl	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contri	oute to the	cause of death?
Records,	v require been sig should b				· · -			1 🗆 Y	es 2 PRo	∃ ☐ Probab	oly 4 Unknown
ecc	e law re has be ie 2 sho	Completed				·		24a. Was a	an 24b. W	ere autops	y findings available detion of cause of
<u>=</u>	Th ate pag	Cou						perfor 1 ☐ Yes	med? de	ath?	□No
Vital	Phyeicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Deat				
o); To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time of	t 3 DOA	at at		ence 6 Other		
ion	Attending ir death. ector: Atter by the funer	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	M 1 🗆 Y	<br Yes 2 □No				
Division	iel or Attendi s after death. el Director: A ed in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, str	eet, factory, office		28f. Location (S City or Town	treet and Number	or Rural F	Route Number,
٥	urs aft										
	Hospitel	edical	29a. Certifier 1 Certifying Physical Examination one)	sician: To the best of my kno ner: On the basis of examina and manner stated	wledge, death tion and/or in	occurred at the time restigation, in my op	ne, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) and man ate and place, ar	ner as state nd due to th	ed. ne cause(s)
	To the Hospitel or vithin 24 hours after or to the Funerel Direct completely filled in b	Me	29b. Signature and title of certifier			29c. License	number	2	9d. Pate signed	(Month, Da	y, Year)
			1 Apr 7	S/5/1/2		0	1587:	2	June	0:	7004
	3		30. Name and address of person who co	ompleted cause of death (Item	1 23а) (Туре.	Print)	0. ~1			1)	
			31. Date filed (Month, Day, Year)	R 25 M	0/N 5	Debl	reiste	noon	~ 6	115	0
	Sta Registr	-	JUN 1 0 2004	32. Registrar's Signa	0 1	29c. License D. Print) Doubs					

Robert Forsberg

			Please I	State of Maryland / Den	ndelible ink. Ensure All partment of Health and M	•	_	
			. POI			3. No. 2004	18321	
}	Physici /Medic	cal	1. Decedent's Name (First, Middle, Last) Robert An		berg	2. Date of Death Month June 7	Day 2004 Year	3. Time of Death 1:30 PM
	Examin		4a. Facility Name (If not institution, give : Greater Baltimore	street and number) Medical Center	4b. City Town, or Location of Death Towson		4c. County of Death Baltimore	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year)					stace (State or Foreign stry) Sylvanuc
Baltimore, Maryland 21215-0036	yland now	by Funeral Director	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	Location		11	0d. Inside City Limits
	with the Mar 3e or 28e-f sh		WD	BAL	Timole			1 ☐ Yes 2 ☐ No
			2906 Summi	+ Ave.	21234.	100	g. Citizen of What Coun USA	try?
	s after death , or Items 2			1 Yes 2 □ No I Yes, Give	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto f	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
	rit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artenent of Health and Mental Hygiene. The man 27 is a marked other then "natural", or Items 23e or 28e-f show njury or other traumatic event, the Maxical Exaculty 1 and the nutified at a njury or other traumatic event, the Maxical Exaculty 1.	ted b	15. Decedent's Edu	Year or Dates: cation 16a. Dec	edent's Usual Occupation re kind of work done during most of working	16	6b. Kind of Business/Inc	dustry
		Completed	(Specify only highest grade	College (1-4or 5+)	+ Teacher.	E	Batimore C	To. School
		To Be	17. Father's Name (First, Middle, Last) Andrew Karl Edwin Forsberg Margaretta Ella Blake.					
	2 should and Men le marker aumatic	1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code)					
	1 and 1 Health em 27		Sandra L. Forsberg 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State					
	Pages nent of nt: If it		1 Rurial 2 Cremation 3 Removal from State cemetery, crematory of other place)					
	permit. Pages 1 an Department of Heal Importent: If item 2 any njury or other once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2325 VORK RD TIMONIUM MD2					
	703 # Q		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate CTR Interval Between Onsert and Death Onsert and Death Onsert and Death Onsert and Death Onsert and Death Onsert and Death					
Į.	Physician		tmmediate Cause (Final disease or condition	Seps				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	1 Dansier L	15 VIVA		della
'n		ner						OF-MAN 24
	ba exacuted ician and burial-transii	cai Examiner						years.
Division of Vital Records, P.O. Box 68760,	e ba e) /sician e buria							
	eath certificate ba exacuted attending physician and for use as the burial-transit	Medi	IF FEMALE:					
	law requires that the d as been signad by the 2 should be detached	edical Certification; To Be Completed by Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		☐ Ectopic pregnancy		23d. Date of delive Month	ery Day Year
							cco use contribute to th	
			, ,			24a. Was an autopsy	autopsy prior to comptetion of cause of	
	reicien: The law s certificate has b lirector, page 2 s		25. Was case referred to medical		26. Place of Death	1 □ Yes a	death?	2₺ No
	Physicie this cert al direct		examiner?	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)				
	ding P h. After t funera		27. Manner of Death 1 □Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Work? 1 □ Yes 2 □ No				
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate h completely filled in by the funeral director, page		2 Accident Investigation 3 Suicide 6 Could not be determined					
			29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
	To t To t	Σ	29b. Signature and title of certifier	_ MD , MPH	29c. License number	290	d. Date signed (Month, 1	Day, Year)
,	12×1		30. Name and address of person who co	ompleted cause of death (Item 23a) (Type	D006046	1	010107	0.10
	1"		Gary T	Chiang MD	6701 N Chai	les st	- lowson	- 2/204
	Sta Regist		31. Date filed (Month, Day, Yeal)	32. Registrar's Signature	booth			

			State of Maryland / Department / Department / Department / Department / Department / Department / Department / Department	artment of Health and Martificate of Death	lental Hygien	711111 10005
	Physicia		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death
	/Medic	al -	ANNA DOROTHY GRAFF 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	June 6	2004 1200 p M
	Examin	er	Chapel Hill Nursing Home	Randallstown		Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign
	Director		216-05-7006 1 1 M 2MF 91 Yrs. Usual Residence of Decedent		7/21/1712	2 Maryland
	Maryland a-f show	tor	MD Carroll 10c. City, Town or Lo	cation SVII1e		10d. Inside City Limits 1 ☐ Yes 2X No
	h with the 23a or 28a at Le not	Funeral Director	10e. Street and Number 2220 Harvest Farm Rd.	10f. Zip Code 21784-6325		Citizen of What Country? USA
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic evant. The Medical Eval. it at finial be notified at once.		1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Spr If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	within 72 ho ane. than "natur is Medicul.	Completed by	(Specify only highest grade completed) (Give life. Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of work DO NOT use retired) ical	ing	Kind of Business/Industry
land 2	ould be filed Mental Hygis arkad othar atic evant, I	To Be Co	10 0 CIEI 17. Father's Name (First, Middle, Last) Julian F. Clarke		e (First, Middle, Maide A. Hilte	ən Sumamə)
Mary	ind 2 should alth and Men 27 is marks ar traumatic	8		ng Address <i>(Street and Number or Rure</i> Harvest Farm Rd		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is any injury or othar tra			osition (Name of natory or other place) Cemetery 06/11,		Location - City or Town, State
Balti	permit. Departm Importa any inju			2. Name and Address of Facility Cva 211 Chesaco Avenue		le Funeral Home Maryland 21237
	Physician /Medical Examiner	ıer	23a. Part. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin. Cause (Disease or injury)	er the mode of dying, such as cardiac o	or respiratory arrest,	Approximate Interval Between Onset and Death
68760,	ificate be executed g physician and as the burial-transit	edical Examin	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	D. Seese		
.O. Box	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physiclan/M		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
<u>α</u>	quires that I n signed by uld be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death? 2☑No 3☐ Probably 4 ☐Unknown
of Vital Records,		Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2□ No
Vita	Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner? Hospital:	Tau .	h (Check only one)	
on of		lon: To	27. Manner of Death 1 Inpatient 2 EProdupate 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	The second secon	28d. Describe how in	6 □Other (Specify) jury occurred
Division	E # : 0	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
_	To tha Hospital or Atta within 24 hours after de To tha Funaral Diracto completely filled in by th	Medical C	29a. Certifier Certifying Physician: To the best of my knowledge, dear (Check only one) Check only one) Certifying Physician: To the best of my knowledge, dear and manner stated.	h occurred at the time, date and place, evestigation, in my opinion, death occurr	and due to the cause red at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	To tha within 2 To tha complet	Me	29b. Signature and title of certifier	29c. License number	29d. E	Date signed (Month, Day, Year)
	5	2	acqueen	D24085	170	re 8 2004
- 1	11		30. Name and address of person who completed cause of death (Item 23a) (Type	5310 OW C	uct Re	21137
	Sta Regist	ate rar	30. Name and address of person who completed cause of death (Item 23a) (Type 17) (Type 17) (Type 18) (Type	Sporte		

			For State Registrar	State of Ma	ryland / [nt of H	ealth an		tal Hygi	ene 3. No. 2001	18326
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Andrew	F.	Hogy	/a			1 1	Date of Death Month une 5,	Day Yeer 2004	3. Time of Death 3:40 P. M
e constant	Examin Funeral		4a. Facility Neme (If not institution, give : St. Joseph Mano 5. Social Security Number 298-24-9476 6. Security Number	r- 911 W.	(In yrs. last bin	ve. Bal	timo	re Cit	y	Date of Birth Month, Day, 1	4c. County of Dea N/A (ear) 9. Bir C C 3. 1921 Or	thplece (State or Foreign ountry)
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or items 23a or 28a-1 show an aumatic event, the M-olcal Exercities may be notified at the most continued to the continued of the most continued of the continued	by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland N/A 10e. Street and Number 911 W. Lake Avent	IE 12. Was Decedent E Amed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:	10c. City, Town Balt	imore C	p Code 2121(dent of Hi ecify Cuba) ispanic Origin n, Mexican, P Specify:		10	g. Citizen of What C U.S.A. 14. Race - Am Black, Whi	10d. Inside City Limits 1 ☑ Yes 2 ☐ No ountry?
Maryland 21215-0036	filed within 72 hou Hygiene. Sthar then "natura ent, the Modical E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12 yr's 17. Father's Name (First, Middle, Last)	cation e completed) College (1-4or 5-	+>	Decedent's Usi (Give kind of w life. DO NOT	ork done d use retired	turing most of C Brot	ther		Church	Vindustry
ırylan	should be fand Mental Is marked o	To Be	Frank 19a. Informant's Name/Relationship (Ty	Hogya, S		. Mailing Addres	s (Street a	Esth	ner	Jus		Simko Zip Code)
ore, Ma	os 1 and 2 and 2 of Health ar if Item 27 is a rother trau		St. Joseph Society of 20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ F		1 - 2 -	1130 N Disposition (Na ry, crematory or			Date	20	timore, M	Town, State
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic en		4 □Donation 5 □Other (Specify) 21. Signatur Funeral Service Licens		New C		nd Addres	s of Facility	/9/04 B Inc	altimo	Baltimore re, Maryl 5 Harford	, Maryland and 21214 Rd.
760,	by Caracteristicate be executed attending physician and attending physician and for use as the burial-transit	icai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a c.	a consequence	of):	de of dying	g, such as ca	ardiac or res	EASE	it,	Approximate Interval Between Onset and Death
P.O. Box 68	The law requires that the death certifica ate has been signed by the attending phage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of the contract of the co	2 🗆 Fetal death	3 ☐ Ectopic 5 ☐ Other (s					23d. Date of de Month	livery Day Year
	w requires that the debeen signed by the a should be detached t	by	Part II. Other significant conditions co.	ntributing to death bu	at not resulting in	n the underlying	cause give	en in Part I,				o the cause of death?
al Recc	n: The law re ificate has be or, page 2 sho	Completed	25. Was case referred to medical					OC Plans of		24a. Was an autopsy performe 1 Yes 2 1	prior to death?	utopsy findings available completion of cause of
Division of Vital Records,	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To Be	examiner? 1 Yes 2 No 27. Manner Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	Hospital: 1 ☐ Inpaties 28a. Date of Injur (Month, Day) 28e. Place of Injur	Year) 28b. 1	Time of njury M	28c. Injun Work 1 📋	er: 4 □ Nursi	ing Home 28d.	5 Aesiden Describe how	ce 6 Other (Sperinjury occurred	
Ď	spitel or A ours after seral Direc filled in by		4 Homicide determined	building, etc	. (Specify)			ne, date and c		City or Town,	State)	
	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical Exemione) 29b. Signature and title of certifier	ner: On the basis of and manner sta	examination an ted.	id/or investigation	n, in my op	pinion, death	occurred at	t the time, dat	e and place, and du	th, Day, Year)
	i		30. Name and address of person who con John T. Everica 31. Date (filed (Month, Day, Year)	ompleted cause of de	path (Item 23a)	(Type, Print)	DOC	349.	52		67:	2004
	Sta	ate		SHD 7	-6 00 0	SLERI	DRIVE	E Sur	TE 3C	8 To	WSOW, HA	RYLAN_D
	Regist	rar	JUN 1 0 2004	Deneur	p 1	aports						

			For State Registrar	State of Maryland		nt of Health and	•	giene	2001	18327
	Physici /Medio Examir	al	Decedent's Name (First, Middle, Las A T T C 4a. Facility Name (If not institution, give	B, John	✓ .	y, Town, or Location of Dea	2. Date of De Month th	Day 2	Year 6 4 County of Death	3. Time of Death
	Funeral Director		5. Social Security Number 6. Se	e cury 16) x 7. Ago (In yrs. 6) IM 219XE	st birthday) If Und Month	Bolling 1 Year If Under 24 Hrs Days Hours Min	8. Date of Bir		9. Birth	place (State or Foreign
	72 hours after death with the Maryland naturel', or frama 23e or 28ef e how dical Examiner must be ricitlified at	rector	10a. State 10b. County	10c. City,		MORE		10g Citi	zen of What Cou	10d. Inside City Limits 1 ⊠CYes 2 □ No
	s after death with the Marylan , or ftama 23a or 28a-f show caminer oust by notified at	Funeral Director	- 2	N GTON ROA1 12. Was Decedent Ever in U.S Armed Forces?	>	edent of Hispanic Origin? (secify Cuban, Mexican, Pue	Specify Yes or No		14. Race - Ameri Black, White	A . can Indian,
5-0036	72 hours afte naturel', or fi lical Examin	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Edi (Specify only highest grace)	1 Tes 2500 lf Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:			Specify: AME	RICAN ICAN INDIAN
2121	fillad within 7 I Hygiene. other than "r ent, Ire Mod	Be Completed	Elementary/Secondary (0-12) Leth grade 17. Father's Nagle (First, Middle, Last)	College (1-4or 5+)	life. DO NOT	DOMESTIC	me (First, Middle	, Maiden	PRI VA	ATE
Maryland	nould be d Mental narked o natic ev	To B	DANIEL WES			CHAR	PLOTTE	LC	MAX	
	s 1 and 2 st f Health and item 27 Is n other traun		19a. Informant's Name/Relationship (TMLDRED E. Jo 20a. Method of Disposition	HNSON 20b. Pla	1008 N	ss (Street and Number or R		B		21229
altimore,	t. Pages rtment of rtant: If i njury or		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen	Removal from State	metery, crematory or 230TUS	other place)	12/04	BA	LTIMO	re, MD
Ba	permi Depa Impo any iu		Dangh_ C		15151 P	and Address of Facility IN C. GREENE AUTIMORE NA	TIONAL P	IKC	ERVICES BALTO N	ND 21229
	Physician /Medical Examiner		23a. Part1. Enfer the disease, or compositions, or composition of the disease, or composition of the disease or condition resulting in death)	a. Due to (or % a conseque	ve Hea		c or respiratory a	rrest,		Approximate Interval Between Onset and Death Wonths
8760,	certificate be exacutad Iding physician and Ise as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	ance of):					
.O. Box 68	certific ding p	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnan- 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	death 3 Ectopic			2	3d. Date of delive	ary Day Year
rds, P	The law requires that the death tte has been signed by the atter page 2 should be detachad for u	þ	Part II. Other significant conditions co	ntributing to death but not result	ting in the underlying	cause given in Part I.		obacco us		ne cause of death?
		Completed					24a. Was autor perfo 1 \(\text{Yes}		24b. Were auto prior to co death? 1 Yes	psy findings available mpletion of cause of
n of	ng Phys iftar this ineral di	tlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Autural 5 Pending investigation		R/Outpatient 3 C 28b. Time of Injury	Other	ath (Check only of Home 5 ☐ Resident 28d. Describe I	dence 6		y)
Divis	To the Hospital or Attendi within 24 hours after death. To the Funarel Director: A completely filled in by tha fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, facto	ry, office	28f. Location (S City or Tox	Street and vn, State)	l Number or Rum	I Route Number,
	e Hospi 24 hour e Funar letely fill	edical	29a. Certifier Certifying Phy (Check only one) 2 ☐ Medicel Exem	rsicien: To the best of my know iner: On the basis of examination and manner stated.	ledge, death occurre on and/or investigation	d at the time, date and place n, in my opinion, death occu	e, and due to the urred at the time,	cause(s) date and	and manner as s place, and due to	tated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	6, no	2:	sc. License number 51018 Son Ave. Sur		29d. Date	signed (Month,	Day, Year)
	7		DOOGIAD 1	ompleted cause of death (Item 2	23a) (Type, Print) 421 Ben	son Ave. Su	je 230,	Balt	imore, N	0 21227
1	Sta Registi		31. Date filed (44 th, Day, Year)	32. Registrar's Signatu	Sport	2				

			1 - For State Registrar	State of M	aryland /		rtment			and M		giene Reg. No		04	18:	328
	Physici /Medic		1. Decedent's Name (First, Middle,	Last) VENKING							2. Date of De Month	Da		Year	3. Time of	Death M
	Examin		4a. Facility Name (If not institution, 3416 KESTON	ORD.	je (In yrs. last bi	irthday)	4b. City,	GWYI	Location of NN OA	K	8. Date of Bir	th		LTIMO		or Foreign
	Funeral Director		217-12-3285 Usual Residence of Decedent	1\\(\frac{1}{2}\)M 2\(\preceder\)F	81	Yrs.	Months	Days	Hours	Min.	(Month, Da 10-4-	ay, Year)		MARY		
	the Marylar 28e-f show	ector	MD • BALT 10e. Street and Number	IMORE	10c. City, Tov	NN C		Code				10a. Ci	tizen of Wi			2 No
	th with 23a or	al Dir	3416 KESTON R	D.				2120	7			_	USA			
36	irs after deal	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 ff Yes, Give Year or Dates:			Vas Deced Yes, spec		spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto F	cify Yes or No Rican, etc.)	0-	Black	- America c, White, e	itc.	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "naturel", or items 23a or 28e-1 show snt, the Medical Examinar must be multified at	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12) —12—	s Education grade completed) Colfege (1-4or		(Give l	lent's Usua kind of wor OO NOT us NE OI	k doné a e retired,	luring mosi)	t of workir	ng		ind of Bus		ustry	т.
	uld be filed v fental Hygie rked other t tic event, Ib	To Be Co	17. Father's Name (First, Middle, L JOSEPH E. JE	ast)		Old			18. Mothe		(First, Middle				. OILL	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Importent: if item 27 ie marked other than "naturel", or items 23a or 28e-1 show any injury or other treumatic event, the Medical Examinat must be rediffed at once.		19a. Informant's Name/Relationsh BESSIE JENKIN 20a. Method of Disposition 1	S (WIFE) 3 □Removal from State	20b. Place comete	3416 of Disposery, crem SON NER ²	KEST sition (Name natory or of FORES Name and	FON Interplace TON In	RD. G ETERA s of Facilit	WYNN 6-14 NS REDI	OAK, Nate OAK, Nate -2004 D FUNEI F. BALT	MARY 20c. L OW I	LAND ocation - C NGS M SERVI	2120 City or Tov	7 wn, State , MAR	
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dicai Examiner	23a. Part I be disease, or shock or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, I are Learn to a many cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to or as c.	ine.	SPE of): of):					CPAT				Approximat Interval Bet Onset and I	ween
.O. Box 6	he death certifics the attending phashed for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetaf deat		Ectopic pro						23d. Date Mont	of deliver	·	Year
<u>α</u>	quires that the de n sign e d by the a uld be detached t		Part II. Other significant condition	ns contributing to death	out not resulting	in the ur	nderlying c	ause give	on in Part I.	SE			_ /		e cause of c	
I Records,	The ate h page	Completed by		NAMY AGE	CAND RE	DEF	mosile	ATO	574	Tres	24a. Was auto perfe 1 🗆 Yes		pr	rior to com eath?	sy findings apletion of c	
Vital	Physicien: The trins certificate har all director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2☐ No	Hospitaf:	ent 2□ER/C	Jutnation	t 3 DC	A Othe	200	of Death	(Check only		6 DOthou	r (Specify	1	
ion of	ding Ph h. After th funeral	-	27. Manner eath 1 Matural 5 Pendin 2 Accident investig	28a. Date of Inj (Month, Date)	ury 28b.	Time of Injury		8c. Injury Work		2	8d. Describe			. , ,,	,	
Division	in the	Certification:	3 Suicide 6 Could r 4 Homicide determi	ned 289. Place of In-	tc. (Specify)						28f. Location (City or To	wn, Stati	θ)			nber,
	the Hospitel hin 24 hours a the Funerel I	edical		g Physicien: To the besi Exeminer: On the basis and manner s	of examination a											5)
	To the within To the comple	Me	29b. Signature and title of centrier	D- 1	4. 7)	290	License	number	-			ate signed			01
7	711		30. Name and address of person	who completed cause of	death (Item 23a) (Type.	Print)	75	101	400	nty	1	WNG.	11	166	
	511		DRIANDO B. (Conmuntal "	W)			1340	Tipu	no	The	e.	2/2	-07		
	Sta Regist		JUN 1 0 201	32. Regist	rar's Signature	100 al	20									

		4	For State Registrar	Stat	te of Ma	aryland		artmen rtificate				ental Hyg	giene Reg. No?	104	18320
	Physicia		Decedent's Name (First, Middle		John	Johns	son					2. Date of Dea Month	une ^{Day} 20	04 Year	3. Time of Death 11:10 p. _M
	/Medic Examin		4a. Facility Name (If not institution	n, give street a 6768 Mil		w Rd.		4b. City,	Town, or	Location	1	777	4c. Cou	nty of Death Ho	ward
	Funeral Director		5. Social Security Number 218-09-7446	6. Sex/ 100 M 2	7. Ag	e (In yrs. las 86	st birthday) Yrs.	tf Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Day	y, Year)	1	place (State or Foreign ntry)
	pu »		Usual Residence of Decedent 10a. State 10b. County		<u>-</u>	10c City	Town or Lo	ocation				February 2	(3, 1910		Maryland 10d. Inside City Limits
	Maryland fluct at	to	Maryland	Howard					F	lighlan	d				1 □ Yes 2 No
	death with the Maryla ms 23a or 28a-f shov roust be mulfied at	Funeral Director	10e. Street and Number		-			10f. Zip					10g. Citizen	of What Cou	•
	eath w	eral	6768 Mink Hollow F	-	s Decedent	Ever in U.S.	13.	Was Deced	ient of Hi		777 iain? (Spe	cify Yes or No-	14. F	Race - Ameri	
980	or iter	þ	1 Never Married 2 Mar 3 Widowed 4 Divorced	ned 1 X	s Decedent yed Forces? Yes 2 1 es, Give ar or Dates:	10101	i		offy Cuba	n, Mexicai Specify:		cify Yes or No- Rican, etc.)	Spe	Black, White,	
21215-0036	c * @	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)		leted) lege (1-4or 5		(Give	dent's Usua kind of wor DO NOT us	rk done d se retired	turing mos)		ng	16b. Kind of	Business/In	ndustry
121	iled withi Hygiene. ther than nt, the M		6 17. Father's Name (First, Middle,	Last)					PI	asterer		(First, Middle,	Maiden Sur	Tucti	on
Maryland	s 1 and 2 should be filed v f Health and Mental Hygie item 27 is marked other i other treumatic event, II	To Be		vard John	son							1	Bertha		nown
Aary	2 shours and N Is ma	87	19a. Informant's Name/Relation					-				i Route Numbe	•	vn, State, Zij	, , , , , , , , , , , , , , , , , , , ,
	s 1 and if Health item 27 other tr		Mrs. Virginia Joh	nson	Wife	20b. Pla	ce of Dispo	sition (Nan	ne of	1	0	and, Maryl		n - City or T	own, State
ПO	& = P		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (5		I from State			matory or o n Chape			06/0	04/2004		Clarksvi	lle, MD
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Sign stup of Funeral Service	Denspe	m	1292		2. Name an	d Addres	s of Facili uneral	Home,	P.A. Pike Ellicot	t City, MI	D 21043	
8760,	Physician and Medical Examiner	dical Examiner	23a. Part1. Edger the disease, o shock, or heart failure. Lis timediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. D	on each li due to (or as	a conseque a conseque a conseque	ince of):	m			13 PAN		1951,		Approximate Interval Between Onset and Death
Box 6	The law requires that the death certificate be executed tte has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 4	es, outcome]Live birth]Pregnant at]Unknown	2 Fetat d	eath 3[⊒Ectopic pr ∃ Other <i>(sp</i>					1	Date of deliv Month	ery Day Year
rds, P.O	quires that I in signed by uld be deta	þ	Part II. Other significant condit	ons contributir	ng to death b	ut not result	ing in the u	inderlying c	ause give	en in Part I	l.		obacco use co		he cause of death?
of Vital Records,		Completed			· , ·								an 24 ssy rmed? 2 No	b. Were auto prior to co death? 1 🏻 Yes	opsy findings available impletion of cause of
Vita	icien: Th certificate rector, pay	Be	25. Was case referred to medical examiner?	Hospital	l:				Othi	20		(Check only o			
of	Phys this al di	n: To	1 Yes 2 No 27. Manner of Death	28a.	1 ☐ Inpation Date of Injuic (Month, Da		R/Outpatie 8b. Time o Injury	nt 3 DC	28c. Injun Worl	4 🗀 140	-	ne 5 Resid 28d. Describe h			(y)
Division	Attending I death. ctor: After y the funer	catlo	1 ☑ Natural 5 ☐ Pendi 2 ☐ Accident invest 3 ☐ Suicide 6 ☐ Could	igation				М	10	Yes 2	_	204 14: //			
Divi	s after deat s Director: sd in by the	Certification:		nined 28e.	. Place of Inj building, et	ury - At hom c. <i>(Specify)</i>	ie, farm, st	reet, factory	/, office		-	City or Tow		mber or Hun	al Route Number,
	To the Hospitel or A within 24 hours after To the Funeral Direct completely filled in by	edical		ng Physician: Examiner: Or an		f examination									
	To the vithin 2 To the comple	Σ	29b. Signature and title of certific	er /	,			290	c. Licenso	number	(17		29d. Date sig		
	/ h		30. Name and address of person	work complete	d cause of c	leath (Item 2	23a) (Tvne	Print)	V	257	7/		7-1-17	-) 4	
_	2		Wayn S	Fellen,	m	340	TEN O	MCI 1	20	um	ps by le	& un	11019	2	
	Sta Registi	-	31. Date filed (Month, Day, Year	2004	32 Registr	ar's Signatu	B	400	Ms.	/			,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 18330 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 6:20AM Kenneth D. Justice JUNE 07 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Days Months Hours XXM 2□F 219-74-0505 45 Yrs. Mary land Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County Baltimore Middle River 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 711 Grantwood Rd USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★★No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. Never Married 2 Married White 1 ☐ Yes XXNo Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Concrete Masonary 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Andrew Jack Justice Sarah Frances Broughman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandy Crisfulli Sister 711 Grantwood Rd Middle RIver Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 6/10/04 Raspeburg, MD. *4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Rosedale Maryland 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition SEVERE METABOLIC HOURS resulting in death) Due to (or as a consequence of): 12 HOURS ACTIC ACIDOSIS Dua to (or as a consequence of) ALCOHUL ABUSE HEPC CIRRHUSIS Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown

Pnysician /Medical Examiner

and

the attending physician hed for use as the buria

detached

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page 2 certificate has

director,

this funeral

within 24 hours after deatl To the Funaral Director: completely filled in by the

Physician:

Attending

9 Hospital death.

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Division

Vital Records, P.O. Box 68760,

Physician

/Medical

MD

Director

Funeral

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Completed

Examiner

Funeral

Director

item 27 is marked other than "neturel", or items 23s or 28s-f show other traumatic event. Its Modified Examinar mast be notified at

within 72 hours after

2 should be fi and Mental F

s 1 and 2 if Health

Pages nent of h

permit. Page Department Important: If any injury or

once.

Examiner

Physician/Medical

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Completed

Be

Certification: To

edical

State Registrar

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

2 No 26. Place of Death (Check only one)

1 Yes 2 No

25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No 27. Manner of Death

Hospital: 1 X Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

3 DOA 2 ER/Outpatient 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

1 Natural

2 Accident

4 Homicide

3 Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number AT 2438946-CIC

29d. Date signed (Month, Day, Year)

62mahmara

29b. Signature and title of certifier

REAL SIDDIQUI, MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUNE 7, 2004

REAL SIDDIQUI

31. Date filed (Month, Day, Year) JUN 1 0

6 Could not be determined

32. Regianar's Signature

201 EAST UNIVERSITY PARKWAY, BALTIMORE, MARTLAND 21218

Pĥys /Me Exa

Fune

		Directo
Lanza, Lydia 6/03/04 310pm	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23e or 28e-f show eny injury or other traumatic event. The Madical Exprising of the motified at
		/Medica Examine
1+	Division of Vital Records, P.O. Box 68760,	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	For Stata Registrar	State	of Marylan	id / Dep <i>Ce</i>	ertificate of	lealth and Death	Mental Hy	/giene Reg. No.	2004	1833
	1. Decedent's Name (First, Midd	de, Last)					2. Date of D Month	eath Day	Year	3. Time of Death
ın al	Lydia Sophia La	anza					June 3			3:10 p. ^M
er	4a. Facility Name (If not institution	on, give street and n	umber)		4b. City, Town, o	r Location of Deat	th		County of Death	
	Gilchrist Cente	-	1 - 1 - 1		Baltimo		100 100		1timore	
	5. Social Security Number 217-01-6343	6. Sex 1 ☐ M XXF	7. Age (In yrs.	85 Yrs.	Months Days	If Under 24 Hrs Hours Min.		ay, Year)	Cou	
	Usual Residence of Decedent 10a. State 10b. Count	у	10c. Cit	ty, Town or I	Location				1	10d. Inside City Limits
Director	Maryland Balti	imore	Ва	ltimo:	ce				,	1 ☐ Yes XX No
ji e	10e. Street and Number				10f. Zip Code				en of What Courted State	
	1315 North Roll	ling Road			21228				erica	
raneral	11. Marital Status 1 □ Never Married XX Ma	Armed f rried 1 Tes If Yes, G	2 X∑X No aive	.S. 13	. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2000 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)		 Race - Americ Black, White, Specify: 	
2 2	3 Widowed 4 Divorce	ed Year or	Dates:						Whi	
Completed	15. Decede (Specify onfy high	ent's Education est grade completed	0	(Giv	edent's Usual Occup re kind of work done DO NOT use retire	during most of wo	orking	16b. Kir	nd of Business/In	dustry
1	Elementary/Secondary (0-12) 12th	College	(1-4or 5+)		Homemaker	4)		Over	Home	
	17. Father's Name (First, Middle	(ast)		1	Tomemaker	18. Mother's Na	me (First, Middle			
חמ									,	
2	Joseph Wilkins 19a. Informant's Name/Relation	shin (Tyna Print)		19h Mai	iling Address (Street	Annie Fo		her City or	Town State Zir	Code)
				3	North Rol					land 21228
	Joseph T. Lanza 20a. Method of Disposition	4 (3011)	20b. F	Place of Disi	position (Name of	7	Date	-	cation - City or To	
	XXBurial 2 Cremation		n State Lak	cemetery, cr eview	ematory`or other pla Memorial	June 2002	, 8	G 1	• 1 1	M 1
1	' 4 □ Donation 5 □ Othe) (Par		22. Name and Addre	2004 ; es of Facility TuC	t oudon la			Maryland ome
	(Xm / Om	Jach.			LE. Hambana nadio	36	20 Wilk	ens A	neral H	1220
_	23a Pert1. Enter the disease, of	or complications that	caused the deat	th. Do not e	nter the mode of dvir				yland 2	Approximate
	shock, or heart failure. Lis	st only one cause on	each line.	۷.		.9,				Interval Between Onset and Death
	disease or condition resulting in death)	a	neumon							drys
	,	Due to	o (or as a consec		- Conc					
-	Sequentially list conditions, if any, leading to immediate	b. Due t	(or as a consec		cenc	<i></i>				100
LAGIIII	Cause, Enter Underlying Cause (Disease or injury	<	O.							
	that initiated events resulting in death) Last	c	o (or as a conseq	quence of):						
3										
adical		0.						- 1		
Physician/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn					2	3d. Date of delive	өгу
2 2	in the past 12 months?		birth 2 Peta gnant at time of c		☐ Ctopic pregnanc	у			Month	Day Year
3	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unk	nown							
	Part II. Other significant condi-	tions contributing to	death but not res	sulting in the	underlying cause give	en in Part I.	23e. Did	tobacco us	se contribute to t	he cause of death?
2							1 🗆	Yes 2	No 3□ Prob	oably 4 Unknown
Completed							24a. Wa	s an	24b. Were auto	ppsy findings available
1							auto	opsy ormed?	prior to co death?	mpletion of cause of
	OS Man and referred to madis	and .				00 Place of Pa	1 Yes	2 No	1 ∐ Yes	2□ No
0	25. Was case referred to medic examiner?	Hospital:	Therefore of	TENO.	Ott	100	eath (Check only		L	1.000.
0	1 Yes 2 No		☐Inpatient 2☐ e of Injury	ER/Outpati 28b. Time	ent 3 DOA	4 Nursing i	Home 5 Res			nospice
0	1 ☑Natural 5 ☐ Pend	18.40	onth, Day Year)	Injury	Wo	rk? Yes 2∐No				
2	3 ☐ Suicide 6 ☐ Coul	d not be	ce of Iniury - At h	ome, farm	street, factory, office		28f. Location	(Street and	f Number or Run	al Route Number,
Certification:	4 Homicide deter	mined 206. Fla	Iding, etc. (Speci	fy)	,, 011100		City or To	own, State)		
	29a, Certifier ertify	ring Physician: To t	he best of my kno	owledge de	ath occurred at the ti	me, date and place	e, and due to the	e cause(s)	and manner as s	stated.
Medical		al Examinar: On the								
Me	29b. Signature and little of certif				29c. Licens				signed (Month,	
	MAN	whe	m		ns	8303		\.I.we	42	×4
	30. Name and address of person	on who completed co	use of death /Ites	m 23a) /Tvo	e Print)		14	J J /-	(
	Aam J. Ch		6601	/ /	DS Charles	St Ba	Homore	mo	znoy	
ė	31. Date filed (Month, Day, Yea			ature						
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DHMH 17 Rev 1/2001

ORIGINAL

		Registrar 1. Decedent's Name (First, Middle, La	State of Maryland #17&19a PER IN		2. D	ate of Death	Davi	3. Time of Death
Physicia /Medic		Gladys	A. Luke			Month Ine 4	Day Year 2004	4 12:40 P
Examin		4a. Facility Name (If not institution, giv	e street and number)	4b. City, Town, or Loc	cation of Death		4c. County of Dea	eth
		Montgomery Gener	*		ney		Montgome	ry
Funeral Director		194-10-7440			ours Min. 8. D	ate of Birth Month, Day, Ye b 9, 19	9. Bi 22 PA	rthplace (State or Foreig country)
3.2		Usuel Residence of Decedent 10a. State 10b. County	10c. City, 1	Town or Location				10d. Inside City Limit
1 sho	ō	MD Montgom	ery Cole	esville				1 ☐ Yes 2
natural', or Items 23a or 28e-1 show deal Examiner must be putified at	rec	10e. Street and Number	.527	10f. Zip Code		10g.	Citizen of What C	ountry?
s 23a or 28e-f show	a D	1413 Rainbow Driv	<i>r</i> e	20905		Ur	nited Sta	ates
or Items	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No	13. Was Decedent of Hispan If Yes, specify Cuban, M		Yes or No- n, etc.)	14. Race - Am Black, Whi	
le di	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2.25 No Si	pecify:		Specify: Whi	te
	Completed	15. Decedent's E (Specify only highest gra-	ducation ade completed) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done durin life. DO NOT use retired)	n ng most of working		. Kind of Business overnment	•
al Hygiene. I other then " vent, I've Me	Com	12		Finger Print Ex				
d oth	Be (17. Father's Name (First Middle Last DEAN ALLISON			Mother's Name (Firs		,	
and Mental Is marked of reumatic ev	P P	Unknown Allison			ara Irene			
I and		19a Informant's Name/Relationship (VIRGINIA MAE	MITH DAUGHTER	19b. Mailing Address (Street and				
Healtl em 2 ther		Virginia Allison 20a. Method of Disposition	20b. Plac	1413 Rainbow Dr	Date		. Location - City or	
Department of Health a Important: If Item 27 Is any injury or other treasons.		1 ☐ Burial 2 【Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Special	Hemoval from State	netery, crematory`or other place) sapeake Cremator	Jun cy 200	9 _	ltsville	
Important in sonce.		21. Signature of Funeral Service Lice	M00986	22. Name and Address of Rapp Funera 933 Gist Av	ıl & Crema	tion Se		
hysician /Medical xaminer		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	one cause on each line. a. Metastatic Ki Due to (or as a consequent b.	dney Cancer w/Po			sis	Approximate Interval Between Onset and Death 6 months
hysician and the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a consequence) Due to (or as a consequence)					
by the attending phys tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregnanc 1 Live birth 2 Fetal de 4 Pregnant at time of deal	eath 3 Ectopic pregnancy			23d. Date of de Month	elivery Day Year
igned be det	by P	Part II. Other significant conditions	contributing to death but not resulti	ing in the underlying cause given in	Part I.	23e. Did tobaco	co use contribute t	o the cause of death?
been sig		Chronic Obstructi	ve Pulmonary Di	sease		1 🗌 Yes	2 X № 3 🗆 P	robably 4 Unknow
peen	Completed	Coronary Atheroso				24a. Was an autopsy performed	? prior to death?	utopsy findings available completion of cause of
e has		History of Breast	and Lung Cance		. Place of Death (Ch	eck only one)	No 1 ☐ Ye	s 2M No
		25. Was case referred to medical					6 □Other (Spe	ecify)
ate has	Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{X} \) No	Hospital: 1 Minpatient 2 ☐ EF		4 Nursing Home	DI I Hesidence		
n. After this certifica funeral director, p	To Be		28a. Date of Injury (Month, Day Year)	8b. Time of Injury at Work?	4 ☐ Nursing Home 28d. I 2 ☐ No	Describe how in		
n. After this certifica funeral director, p	To Be	examiner? 1 ☐ Yes 2 X No 27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	R/Outpatient 3 DOA Other. 8b. Time of lnjury at Work? M 1 Yes	28d. I 2 □ No 28f. L	Describe how in	njury occurred and Number or F	tural Route Number,
n. After this certifica funeral director, p	Certification; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying Pi	28a. Date of Injury (Month, Day Year)	R/Outpatient 3 DOA Other: 48b. Time of Injury 28c. Injury at Work? M 1 Yes e, farm, street, factory, office	28d. 1 2 □ No 28f. L date and place, and d	ocation (Street City or Town, Si	njury occurred t and Number or R late) e(s) and manner a	s stated.
4 hours after death. Funeral Director: After this certificately filled in by the funeral director. p	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 2 Medical Examiner 1 Certifying Plant of the control o	28a. Date of Injury 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	R/Outpatient 3 DOA Other: 48b. Time of Injury 28c. Injury at Work? M 1 Yes e, farm, street, factory, office	28d. I 2 No 28f. L date and place, and dan, death occurred at	ocation (Street city or Town, Si	njury occurred t and Number or R late) e(s) and manner a	s stated. e to the cause(s) th, Day, Year)
n. After this certifica funeral director, p	edical Certification; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigated investigated 4 Homicide 29a. Certifier (Check only one) 1 Yes 2 No 5 Pending investigated determined	28a. Date of Injury 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	R/Outpatient 3 DOA Other. 28c. Injury at Work? M 1 Yes e, farm, street, factory, office edge, death occurred at the time, on and/or investigation, in my opinion 29c. License nu D35045	28d. I 2 No 28f. L date and place, and den, death occurred at	Describe how in cocation (Street Property or Town, Street Property or T	and Number or Rate) a(s) and manner a and place, and du Date signed (Monner)	s stated. e to the cause(s) th, Day, Year)

			For State Registrar		State	of Ma	ıryland	/ Depa	artment of H	lealth Death	and M	lental Hy	giene Rag. No.	200	L	18	333
			1. Decedent's Name	e (First, Middle	le, Last)	***	-					2. Date of De			gr	3. Time	of Death
1	Physici /Medic		MARY CL	ARA LE	0							JUNE	5	200		9:	15 A™
1	Examin		4a. Facility Name (I				r.		4b. City, Town, o		of Death			County of D		T 1077	
			5. Social Security N		N NURSIN		1E (In yrs. las	t birthday)	BALTIMO If Under 1 Year	KE If Under	24 Hrs.	8. Date of Bir	th	LTIMO:	Rithele	on (State	or Foreign
	Funeral Director		280-20-09		1 M 2 T		82	Yrs.	Months Days	Hours	Min.	MARCH	7 Year)	922 Y	Country Oun2	Stow	m, OH
	P .		Usual Residence of				10- 01- 1	F									
	show	ž	10a. State	10b. County	more Cit		10c. City, 1	imore							100		City Limits s 2 ☐ No
	28a-f	ect	10e. Street and Nur		more cit	У	Dalt	THOLE	10f. Zip Code				10a. Citi	izen of What	Countr		
	3a or	Funeral Director			vedere A	ve.			21239				_	JSA		, -	
	death	nera	11. Marital Status		12. Was D		er in U.S.	13. \	Was Decedent of H	ispanic Or	rigin? (Spe	ecify Yes or No	1	14. Race - A Black, W			
36	or Ita		1 Never Marri		ried 1 🗆 Ye	es 2 🛣 N Give	io		I ☐ Yes 2 ☒ No	Specify		riidari, did.)		Specify:			
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "neturel", or Itams 23a or 28a-f show ant, the Micrical Examiner must be neillied at	Completed by	3 X Widowed		Year of Year o	or Dates:		16a Decer	ient's Usual Occup	ation			16h Ki	ind of Busine			
15	in 72 n "ne	piet	(Spec	ify only highe	st grade complete	ed) e (1-4or 5		(Give	kind of work done	during mos	st of worki	ng	100.10	ind of busine	33/11/04	311 y	
212	d with giene ar tha	Com	8	ridary (0-12)	Colleg	19 (1-40) 3		Sales	Associa	te			C1	othing	g		
pu	be file tal Hy d oth	Be	17. Father's Name							18. Moth	er's Name	(First, Middle	, Maiden	Sumame)			
Maryland	d Men narke	T _o	Dominic			D 1		105 Mailie	ig Address (Street	-		Abbatti		. Town Class	- 7i- 0	'a da l	
Ma	d 2 st th and th and traun		19a. Informant's Na				iter		Searay						θ, <i>Ζ</i> Ι <i>ρ</i> Ο	000)	
ē,	Heal Heal Hem S		20a. Method of Disp	position			20b. Plac	e of Dispo	sition (Name of natory or other place	1	- 0	ate		cation - City	or Town	n, State	
E C	Page nent o nt: If		1 🌠 Burial 2 ` 4 🗌 Donation		3 □Removal fro Specify)	om State		Cathe		10)	June 20	04	В	Baltimo	ore,	MD	
Baltimore,	perrat. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel; or Itams 23a or 28a-f show any njury or other traumatic event, the Middle Examination and Le nullified at ODGs.		21. Signature 6 Fu	ineral Sec	censee	MC	1220	22	Name and Addre				Fun	eral H	Home 210	PA 61	
			23a. Part1. Enter t	he disease, o	r complications th	at caused	the death.	Do not ent	er the mode of dyin	ig, such as	s cardiac o				Δ	Approximaterval Be	
Ų	Physician	s l	Immediate Cause	(Final				NIC	down		Tonc	une				onset and	
	/Medical Examiner		resulting in death)		Due	to (or as a	consequer	nce of):	(OV)	,						<u>.</u>	
	Lxammer	_	Sequentially list co	nditions,			OUDSERUD E		7505101						1/4	Zv.	4115
	uted 1 ansit	Examiner	cause. Enter Under Cause (Disease or	orlying -	.	(51.51.51.51.51.51.51.51.51.51.51.51.51.5											
oʻ	an and rial-tra	Еха	that initiated events resulting in death)	Last	c. Due	to (or as a	a consequer	nce of):									
38760,	cate be executed physician and the burial-transit	dicai			d										+		
9	ertification plans in a series	/Med	IF FEMALE:		23c If yes	outcome	of pregnanc	.,							1.1		
Вох	death certifi e attending d for use as	by Physician/Me	23b. Was deceden in the past 12	months?	1 ☐ Liv	ve birth	2 Fetal de	eath 3	Ectopic pregnancy Other (specify)	,			,	23d. Date of Month		ay	Year
0	the d	hysi	1 ☐ Yes 2 9 ☐ Unknown			nknown							- 1				
ď	w requires that the deatf been signed by the atte should be detached for	by P	Part II. Other signif		_			-		en in Part	L			ise contribute			
ord	equire en sig			Concor	100-	MU	277-1	ura	ZCJ			1 🗆	Yes 2	No 3□	Probab	oly 4]Unknown
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of Vital	Physicien: this certific ral director,	o Be	25. Was case referexaminer?	/	Hospital:	□lonatio	nt 2 EF	2/Outpation	t 3 DOA Oth			n <i>(Check only d</i> me 5 ☐ Resi		S □Othor (9	Concept)		
of	ding Physi th. After this of funeral dire	n: To	27. Manner of Peat	th	28a. D	ate of Injur	v 28	Bb. Time of				28d. Describe			pecny)		
ior	Attending For death.	atio	1 Alatural 2 Accident		igation	nonan, baj	7 (02)	пцату		Yes 2]No						
Division	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 🗍 Suicide 4 🔲 Homicide	6 Could determ	-inne 200. F	lace of Inju uilding, etc	ury - At home :. (Specify)	e, farm, str	eet, factory, office			28f. Location (City or To	Street an wn, State	d Number or)	Rural F	Route Nu	mber,
	spitel ours a neral (ai Ce	29a. Certifier	Certifyi	ng Physician: To	the best of	of my knowle	edge, deati	occurred at the tir	ne, date a	nd place,	and due to the	cause(s)	and manner	as state	ed.	
	n 24 h	edical	(Check only one)	2 Medicel	Examiner: On the	ne basis of manner sta	examination	n and/or in	vestigation, in my o	pinion, de	ath occurr	ed at the time,	date and	place, and	due to th	ne cause	(s)
	To the To the Comp	Σ	29b. Signature and	title of pertific	er /	1//	/		29c. Licens		10			e signed (M			
	1.		1	Man	6 4/12	tul	M.		ν	20	390			5/7/	60	UY	
	K		30. Name and add		who completed of	cause of d	eath (Item 2	За) (Туре,	Print)	1011 1	12.	Phone m	1.62.1	7177	1		
	Sta	ate	31. Date filed (Mon) 3	2. Registra	ar's Signatur	θ /	Print) 7/2 1/2 1/2 1/2	- The pe	1	DININ	VIIK	21 2)	-		
	Regist		JU	N 0 9 2	2004	MARI	15	Cons	the same								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM #16b&17 per fh g832 6/10/Gertificate of Death Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** enelo June 2004 /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Sykesville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2**X**F Months 62 Yrs. 520-48-7666 Director July 23, 1941 India Usuel Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Marylenc 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23e or 28e-f show the Medical Examiner must be redified at 1 ☐ Yes 2 No Director Ellicott City Maryland Howard 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21043 United Kingdom 3946 Old Columbia Pike Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Çuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1□ Yes 2X No Specify: White Specify: <u>۾</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Maintenance College (1-4or 5+) Elementery/Secondary (0-12) Instructional Assistant EDUCATION Department of Heelth end Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, if once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Lest) Mary Phillips Charles Phillips CHARLES MILLMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 3946 Old Columbia Pike Ellicott City, Maryland 21043 Mr. Arthur Linthicum Husband 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Sykesville, Maryland 06/14/2004 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation Services, Inc. 21. Salat e of Funeral Service Licens 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 100535 Part1. Enter the disees, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final diseese or condition resulting in death) /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examine attending physician end for use es the bunel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of):

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. within 24 hours efter death.

To the Funerel Director: After this completely filled in by the funeral

Baltimore, Maryland 21215-0020

Pert II. Other significant conditions cor Gastro ESopha	((ause given in Part I.		e contribute to the cause of death?
joint disease	obstrue	ctive slee	ep apne	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?
				1 ☐ Yes 2 🖼 🕏	1 □ Yes 2 □ No
25. Was case referred to medical			26. Place of De	eath (Check only one)	
examiner?	Hospital: 1 ☐ Inpatient 2 ☐	IER/Outpatient 3□ DO	A Other: 4 Nursing	Home 5 ☐ Residence 6 ☐	Other (Specify)
27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury M	8c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury of	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, factory (y)	, office	28f. Location (Street and N City or Town, State)	umber or Rural Route Number,
29a. Certifier Certifying Physical (Check only one)	sician: To the best of my knoner: On the basis of examina and manner stated.	wledge, death occurred attion and/or investigation,	at the time, date and place in my opinion, death occ	e, and due to the cause(s) and urred at the time, date and pla	d manner as stated. ice, and due to the cause(s)
29b. Signature and title of certifier	11/1	29c	License number		igned (Month, Day, Year)

Westminster MD 21157

State Registrar

31. Date filed (Month, Day, Year) JUN 1 0 2004

Willer

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

		1 - For State Registrer	State of M	laryland / Dep <i>Ce</i>	ertificate of	Health and M Death		iene eg. No. 200	+ 18335
		Decedent's Name (First, Middle	, Last)				2. Date of Dea		3. Time of Death
	Physician /Medical		bert Lee				JUNE	7 2004	12:500
	Examiner	4a. Facility Name (If not institution	give street and number. Health (4b. City, Town, o	Itimore	,	4c. County of De	
	Funeral	5. Social Security Number	6. Sex 7. A	ge (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day		rthplace (State or Foreign Country)
- 1	Director	579-52-1061	1₹M 2□F	61 Yrs.	Months Days	Hours Min.	DEC 20	, 1942 Soi	ith Carolina
	and and	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	n the Marylan r. 28a-1 show Lincitied at Irector	Maryland N/	4		Ba	altimore			1 XYes 2 No
**	with the Mar	10e. Street and Number	•		10f. Zip Code		1	0g. Citizen of What C	Country?
1112	death with the Maryland ms 23s or 28s-f show I must by notified at the mast by	1216 N. August			2122			USA	
8-0-	r Items 23e	11. Marital Status 1 □ Never Married 2∑ Marr	12. Was Deceden Armed Forces	t Ever in U.S. 13.	. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
5	by San	3 Widowed 4 Divorced	ed 1 Tes 27 If Yes, Give Year or Dates		1 ☐ Yes 2 No	Specify:		Specify:	Black
5-0	ed within 72 hours after Vgjiene. ier than "natural", or ite ier than "madral Examine to my film of the completed by Fui	15. Decedent (Specify only highes		16a. Dece	edent's Usual Occup be kind of work done	oation during most of worki d)	ing	16b. Kind of Business	s/Industry
2121	within sne.	Elementary/Secondary (0-12)	College (1-4or	· 5+)		a) Supervisor	i	Appetment	Complan
	Hygi hygi ant ner C	17. Father's Name (First, Middle,	Last)	rali	iteriance c	18. Mother's Name		Apartment Waiden Sumame)	. Comptex
lan	d ta b y O W	June Mitchell			=	Lucy M.	Rogers		
Maryland		19a. Informant's Name/Relations		19b. Mail	ling Address (Street	and Number or Rura	ul Route Number	, City or Town, State,	Zip Code)
13	1 and Health Pm 27	Elinder Mitchel	l/Wife	20b. Place of Disp	osition (Name of			orc, MD 21 20c. Location - City o	
Jo P	ages ant of	1 ☐ Burial 2 XCremation '4 ☐ Donation 5 ☐ Other (S)		9	ematory`or other place ematory	nc. 6/8/		Baltimor	
\mathcal{L} \mathcal{L}	mit. F partme portar y injur	21. Signatur of Funeral Service	Lice						
Ø m	Depo Imp		gorchik					nc. re, MD 212	
		23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on each	ed the death. Do not en line.	nter the mode of dyir	ng, such as cardiac c	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical	Immediate Cause (Final disease or condition resulting in death)		TRO- INT	ESTINAL	BLEE	DING		3 DAYS
	Examiner		,	s a consequence of):	FAILU	DE			2 YEARS
	ner ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		s a consequence of):				* ** *** ** ** ** ** ** ** ** ** ** **	
19	executed an and rial-transit Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. ET	HANUL s a consequence of):	ABUS	le .			20 YEARS
760,	ate be executed thysician and the burial-transit		d	o a outrooquorito or,					
99	ifficate ig phy as the		3 0.						
Box	eath certifi attending for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom		☐Ectopic pregnancy	,		23d. Date of de Month	olivery Day Year
() 0	S the	1 Yes 2 No	4□Pregnant a 9□Unknown	at time of death 5	☐ Other (specify) _			TV GTGT	Suy Foul
~ <u>a</u> .	gned by be detac	Part II. Other significant condition	ns contributing to death	but not resulting in the	underlying cause giv	ren in Part I.	23e. Did tot	pacco use contribute t	o the cause of death?
rds	quires the signer of the signe						1 □ Ye	es 2□No 3□P	robably 4 Unknown
Records	The law require te has been sage? should completed						24a. Was a autops	v prior to	utopsy findings available completion of cause of
	ician: The certificate he corr. page							2 □ No 1 □ Ye	s 2DNo
Vital S	s certif	25. Was case referred to medical examiner?	Hospital: 1 Inpat	ient 2 ER/Outpatie	ent 3 DOA Oth	26. Place of Death		e) ence 6 □Other <i>(Sp</i> e	noifu)
20	ing Physical of Tool; Toon; To	27. Manner of eath	28a. Date of In					w injury occurred	July
Sion		1 Natural 5 ☐ Pendin 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	pation		M 1 🗆	Yes 2 □ No			
3 5	ert Ingele	4 Homicide determ	ined 286. Place of It	njury - At home, farm, s atc. <i>(Specify)</i>	treet, factory, office	4	City or Town	reet and Number or R n, State)	lural Houte Number,
11/	C Te a		g Physician: To the bes						
		one)	Examiner: On the basis and manner s						
	within To the comile	29b. Signature and title of certified	11 011	1, MY	29c. Licens	_		9d. Date signed (Mon	^
	10	30. Name and address of person	who completed cause of	death (Item 23a) /Typo		9177		JUNE O	, 2004
	0		HCARE 90			RE MOD	1229		
	State	31. Date filed (Month, Day, Year)	32. Regis	trar's Signature	books)			
8	Registrar	JUN 1 0 2004	peret	10 14	oour				

This is a re-created death certificate-if original is found please destroy original-gap 6/8/2004 Margaret A. McDonald 04 - 2179Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 CJ 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** March 2004 04:15 P.M Margaret A. Mc Donald 4a. Facility Name (If not institution, give street and number)

Lorien @ /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Riverside Belcamp 1123 Belcamp Garth-Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, 1/11/20 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Year 1 ☐ M 2 🕱 F 84 Yrs Director 220-12-4800 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show other treumatic event, the Medical Enantrer must be notified at XXYes 2 No Director MD Harford Aberdeen the 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? or Items 23a 41 Green Avenue 21001 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 2 Specify: White 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) then Elementary/Secondary (0-12) Hygiene. permit. Pages 1 and 2 should be filled wil Department of Health and Mental Hygiens Importent: If item 27 is marked other the any injury or other treumstic event Homemaker In home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul D. Butts Agnes A. MacDonald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Lilley (Brother) 41 Green Ave., Aberdeen, Md 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) R.A.Ferris & Co., Inc. 3/29/04 West Chester, PA 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
per dvr 333 South Parke St., Aberdeen, MD 21001-3399 21. Signature of Funeral Service Licensee Kirsten A. Unglesbee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician COMPOUND LEG FRACTURE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Cause (Disease or injury that initiated events resulting in death) Last burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Box 6876 Physician/Medical as the t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy õ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 9☐ Unknown 5 ☐ Other (specify) Division of Vital Records, P.O. the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertensive Artherosclerotic Cardiovascular Disesse 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No 24a. Was an has autopsy performed? Dementia 1X Yes 2□ No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence the (Specify) Scene 1 ☐ Yes 2 XNo 2 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 9:25 A.M 1 ☐ Yes 2 📉 No death. 2/9/04 Subject assaulted at home 2 Accident filled in by the Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 41 Green Avenue Aberdeen, Maryland 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \tomicide Home Hospitel the Funeral 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 24 the 29c. License number 29d. Date signed (Month, Day, Year) 2 29b. Signature and title of ce O.C.M.E. March 30, 2004 me and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) 32. Re JUN 0 8 2004

FONKA-

70//AKm 111 Penn Street, Baltimore, Maryland 21201
32. Registrary Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 4:15 101 2004 OLIVER Ε. McKAY/Medical Baltimose Baltimore Clity

(In vrs. last birthday)

H Under 1 Year | H Under 24 Hrs. | B. Date of Birth (Month. Day, Year)

Months Days Hours Min. | MAR. 9, 1934 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Sinai Hospital 06 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 → M 2 □ F S.C. Director 238-46-0558 Patient Known as Oliver McKay

Baltimore, Maryland 21215-0036 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Yes 2 No Director M.D. N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4408 Belle Avenue 21207 U.S.A. s 1 and 2 should be filed within 72 hours after death v f Heatth and Mental Hygiene. item 27 Is marked other than "natural", or Items 23s Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? ☐XYes 2 Yes, Give 1 Never Married 2 Married 2 No Specify: Black 1 ☐ Yes 2 ➡No Specify: 3. Widowed 4 Divorced þ Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Levindale Nursing Elementary/Secondary (0-12) College (1-4or 5+) Driver Home 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Samuel McKay Sr. Jessie Anna Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4408 Belle Ave. Balto., M.D. 21207 Darryl McKay- Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1 Department of H Important: If itel any injury or oth 1 Suburial 2 Cremation 3 Removal from State 5/24/2004 Owings Mills, M.D. Garrison Forest 22. Name and Address of Facility Nutter Funeral Home Inc. 2501 Gwynnsfalls Pkwy.Balto., M.D. 21216 21. Sign ture of Fundral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis 2 days **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No certificate 1 Tes 1 Tes to the Hospital or Attending Physician: After this certification 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 17, 2004 RES-000 30. Name and address of person who completed cruse of death (It im 23a) (Type, Print) Sinai Hospital of Baltimore Rybak, MD Karen J.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 1 0 2004

2. Registrar's Signature

			For State Registrar	State of Mary	•	artment of F			ene 2004	18338
			Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death
	Physici /Medic		Edward V	Vilson	Martin	1		June 7,	2004	3:20 a M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death	1	4c. County of Death	1
			Manor Care - Ross			Rossv			Baltimo	
	Funeral		Social Security Number 6. Se	7M 2 1 F	n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	Year) 9. Birth	nplace (State or Foreign untry)
	Director		213-05-3402	8	7 Yrs.			June 1,	1917 Ma	ryland
	and		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo	ocation				10d. Inside City Limits
	danyl f sho	៦	Maryland Baltimo	m 0	Dorrs	Hall				1 ☐ Yes 2X No
	28e-	Director	Maryland Baltimo:	Le	Terry	10f. Zip Code		10	g. Citizen of What Cou	untry?
	with Ba or	٥	2007	# 0 17		2	1236		USA	
	ne 23	Funerai	3907 Hannon Court	12. Was Decedent Eve	r in U.S. 13.	Was Decedent of H		pecify Yes or No-	14. Race - Amer	
' 0	r iten	표	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 X Yes 2 □ No	1			o Rican, etc.)	Black, White	e, etc.
93	hours after deeth with the Maryland tursi; or Iteme 23a or 28e-f show at Examinat must be notified at	þ	3 \ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1⊡Yes 2∭ No	Specify:		Specify: W	hite
21215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	ication	16a. Dece	dent's Usual Occup	nation during most of wor	kina 1	6b. Kind of Business/l	ndustry
2	within ene. then "	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)			
2	filed with Hygiene. Ither than	ပ္ပ	12	n/a	Mac	chinist			Stee1	
nd		Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, Ma	aiden Sumame)	
<u>X</u>	should be nd Mental marked c	2	George Stan	/	artin		Bertha	М.		Smith
Maryland	0 0 0 0		19a. Informant's Name/Relationship (T)						City or Town, State, Z	
	C = 64 F		Barbara Smith/Daug						Hall, Mary	
0	S = = 0	1	20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ I	Removal from State		osition (Name of matory or other plac			Oc. Location - City or 1	
Ē	men tent: jury		' 4 ☐ Donation 5 ☐ Other (Specify,		Jessop C		6/11	/04	Sparks, Mar	ryland
Baltimore,	permit. Pege Department of Importent: if any injury or once.		21 Simulato Fun ral Service Ucens	eary	L	2. Name and Addre	eral Home	e of Dula: Timoniu	ney Valley m. MD 210	Inc.
			23a. Part1. Enter the disease, or comp shock, of heart failure. List only of	lications that caused the	e death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arres	st,	Approximate
			Immediate Cause (Final	1	, ,					Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	aDue to (or as c	onsequence of):					
	Examiner				nnent	Ish	anne	Alta	ch	
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a c		1,1100		Alta		
1	uted d ansit	Examine	Cause (Disease of Apply that initiated events	Den	musto		ount	Diffe	ne	
Ć	exec en an rial-tr		resulting in death) Last	Due to (or as 🕡	onsequence of):	, 1	for			
8760,	The law requires that the death certificate be executed to has been signed by the attending physicien and sage 2 should be detached for use as the burial-transit	licai		d. lim	Joor	anne	SERV	Treby		
9	tifica og phy as th	edi								
Вох	leath certifica attending ph	Physician/Med	23b. was decedent pregnant	23c. If yes, outcome of ; 1 ☐ Live birth 2 [⊒Ectopic pregnance	v		23d. Date of deliv	,
-	deat	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at tim		Other (specify)	<u>'</u>		Month	Day Year
P.O.	at the by th tache	hys	9 🗆 Unknown	9 Onknown						
	res that the de signed by the a be detached	by F	Part II. Other significant conditions co		not resulting in the u	inderlying cause giv	en in Part I.	23e. Did toba	icco use contribute to	_
rd	w require been sig		Delinah	-tunny				1 🗌 Yes	: 2 □ No 3 □ Pro	bably 4 Onknown
Vital Records,	awre as be	Completed		,				24a. Was an autopsy	24b. Were aut	topsy findings available ompletion of cause of
æ	The la	E						perform	ed? death?	2 No
ital		a	25. Was case referred to medical				26. Place of Dea	th (Check only one		
\geq	S S D	O B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3 DOA Ott	ner: 4 ursing H	ome 5 ☐ Residen	ce 6 □Other (Spec	ify)
J Of	ding Ph. h. After th funeral	T ;u	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time o	f 28c. Inju	ry at	28d. Describe how	vinjury occurred	
<u>ö</u>	Attending r death. ector: After by the fune	atlc	2 ☐ Accident investigation				Yes 2□No			
Division	r Att	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (reet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	rs after ral Dir	Ce								
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai	29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medical Exam	sician: To the best of n iner: On the basis of ex and manner stated	ramination and/or in	th occurred at the till estigation, in my o	me, date and place opinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)
	thin the complex	Mec	29b. Signature and title of certifier	0	-	29c. Licens	se number	29	d. Date signed (Month	l, Day, Year)
1	F≯Fö		1 Jan	w	M)	D	31466	1	6181	04
,	14.		30, Name and address of person who o	ompleted cause of death	h (Item 23a) /T	Print)		7) - (,
	1 ,		SHDAII3 A - L	HAPHM 1	32 i √	V. Enta	IN SF	Souto	308 RA	18. MD 2120
	Sta	ite.	31. Date filed (Month, Day, Year)	32. Registrar's	ignature	4		arvoc.	1200	~
	Regist		JUN (9 200	William L	4 Spark	20			(f. m) 2)20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 1 - For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Year 2004 Physician Roland V. Maynor June 4, 8:00 P M /Medical une 4,2004 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Towson Baltimore Co. Gilchrist Center @ GBMC Date of Birth (Month, Day, Year)

June 25,1933

9. Birthplace (State or Foreign Country)
West Virginia If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Months Days Hours 1⊠M 2□F 70 Yrs Director 233-52-9335 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 27 is marked other than "natural", or itama 23a or 28a-f ehow rtraumatic evant, Ita Madical Examinar must be notified at 1 ☐ Yes 2 TNo Dundalk Maryland Baltimore Direct 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 United States 7802 St. Bridget Lane 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1⊈Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7: h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Electrician Steel Industry 8 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ethel Buckland Vernon Maynor ပ္ Jaynok, 1 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 is rr any injury or othar traum once. 7802 St. Bridget Lane Dundalk, Maryland 21222 Mrs. Janet Maynor / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 ₺ Cremation 3 □ Removal from State Hilltop Service Corp. 6/9/2004 Towson, Maryland Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 4 an 7922 Wise Ave. Dundalk, Maryland 21222 23a Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) months Physician CANCER UNG /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of it jury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown leted 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Hospital: Other: 4 Nursing Home 5 Residence 6 the (Specify) 65 PICO 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospitai or Attanding 5 Pending investigation To the Hospital or Attanding within 24 hours after death.
To the Funaral Director: After completely filled in by the fun Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

10

State Registrar 29a. Certifier (Check only one)

29b. Signature and title of certifier

6701 G BMC 31. Date filed (Month, Day,

· mo

29c. License number

1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

June 5, 200 %

with 30. Name and address of person who completed cays of death (Item 23a) (Type, Print)

Balxo md 2120% N. Charles St.

32. Registrar's Signature Year) JUN 1 0 2004

		For State Registrar	State of Maryland		rtment of Health and tificate of Death		ne No. 2004	18340
Physic	ian	1. Decedent's Name (First, Middle, Last)	ner Mary Molesw			2. Date of Death Month June 9,		3. Time of Death
/Med Exami	ical	4a. Facility Name (If not institution, give st FutureCare Cherry	reet and number)	701 011	4b. City, Town, or Location of Dear Reisterstown		4c. County of Death Baltimo	1
Funera Director		217-20-0373	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birth	place (State or Foreign Intry) W York
Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Md. Baltimos	re Gly	own or Loc	cation			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
h with the 23a or 28s	ai Director	10e. Street and Number 18 Glyndon	Ave.		10f. Zip Code 21071	10g.	U.S.A.	untry?
Nore, Maryland 21215-0035 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, tra Medical Event and matter conflicted at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	l II	Vas Decedent of Hispanic Origin? (\$ Yes, specify Cuban, Mexican, Puel Yes 2 \times Yes Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify: W}	
21215-0036 ad within 72 hours at giene er than "natural", or tura Medical Exertion	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation 1 completed) 1 College (1-4or 5+)	(Give life. L	ent's Usual Occupation kind of work done during most of wo DO NOT use retired) USEWITE	rking 16t	Homemal	,
yland 2 yland be filed whental Hygis arked other atticevent, to	To Be Co	17. Father's Name (First, Middle, Last) John Thomas	Allender			me (First, Middle, Mai	den Surname)	
e, Maryland 1 and 2 should be file Health and Mental Hy tem 27 is marked oth		19a. Informant's Name/Relationship (Type Edwin L. Moleswor			g Address (Street and Number or Alyndon Ave., Gly:	ndon, Md.	21071	
Baltimore, permit. Pages 1 a Department of Her Important: if item any injury or otha		20a. Method of Disposition 1 ABurial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State Even	etery, cren	n Mem. Gardens J.	une 11,200		rg, Md.
Balt permit. Depart Import		21. Signature of June 13 Service Licents at 23a. Part 1. Enter the disease, or complic	aut		Name and Address of Facility Eckhardt Funeral 11605 Reistersto			5, Md. 21117
8760) Tate be executed whysician and whysician interpretation in the burial-transit	Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	ce of):	votic Cruebial V	asculer dis	spase	Interval Between Onset and Death
I Records, P.O. Box 68760 The law requires that the death certificate be executed at the assented by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	ath 3	Ectopic pregnancy Other (specify)		23d. Date of deli	very Day Year
cords, P. w requires that t been signed by should be deta	ρ	Part II. Other significant conditions con	tributing to death but not resultin	ng in the u	ndertying cause given in Part I.		cco use contribute to	4
	Completed					24a. Was an autopsy performed	g? prior to death?	topsy findings available completion of cause of 2 No
on of ding Phy h. After this funeral d	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	ospital: 1 Inpatient 2 ER 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hombuilding, etc. (Specify)	Bb. Time of Injury	Other: 4 💆 Nursing 28c. Injury at Work? M 1 🗆 Yes 2 🗆 No	ath (Check only one) Home 5 Residence 28d. Describe how 28f. Location (Stree City or Town, S	injury occurred at and Number or Ru	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical Ce				n occurred at the time, date and plac vestigation, in my opinion, death occ			
To the within To the comple	Mec	29b. Signature and title of certifier	\	\supset	29c. License number		Date signed (Month	
10			10 22 Mai	5}	Reisterston	MD SII	136	
Regi	state strar	31. Date filed (Month, Day, Year) JUN 1 0 200	32. Registrar's Signatur	в	all of			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend Item 27 pestage of Maryland/10-programent of Health and Mental Hygiene Certificate of Death Reg. No. Z 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 4.55 PM 2004 4a. Facility Name (If not institution, give street and 4b. City, Town, or Location of Death 4c. County of Death Baltimare 4 Ture corre If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Days Months Hours 1 □ M 2√2 F 217-07-4481 84 May 2, MD. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. Baltimore Dundalk 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6740 Railway Avenue 21222 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 ☐XNo Specify: Specify: White 3 Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **Housewife** Own Home 8 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sophia Wojcik Paul Woicik 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6740 Railway Avenue, Dundalk, Md. 21222 Joseph A. Novak son 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State June 4 Donation 5 Other (Specify) Bayview Crematory 2004 Baltimore City, MD Signature of Funeral Service License ²² Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonis 1 WK Due to (or as a consequence of) Del Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o) as a consequence of: Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the ceuse of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

and

attending physician

Physician

/Medical

Examiner

Funeral Director

2

Be Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel" ~ " any injury or other traumetic exercising.

Physician/Medical Examiner eral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached þ Completed Be Certification: To

Physicien: The law requires that the death certificete be executed

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death.

efter

within 24 hours e To the Funeral D completely filled To the Hospital

Medical

Division of Vital Records, P.O. Box 68760

1 Yes 2 10 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mapner of Death 1 ANatural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Fending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registra

1. Date filed (Month, Day, Year) JUN 1 0 2004

29b. Signature and title of certifier

(Check only one)

32. Registrar's Signeture

accom

30. Hame and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

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		For State		aryland / De	Indelible Ink. partment of Ho <i>ertificate of D</i>	ealth and M	lental Hyg	piene 2001	18342
Physici /Medic Examin	al	4a. Facility Name (If not institution, give	(IMMD)		4b. City, Town, or	Location of Death	2. Date of Dea Month JUNC	Day Year	4 853p M
Funeral Director		196-34-8199 Usual Residence of Decedent		e (In yrs. last birthd: 59 Yrs	ay) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sep 21,	(Year) 9. Bi 1944 Pe	rthplace (State or Foreign Country) nnsylvania
death with the Maryland ms 23a or 28a-f show Linast be notified at	irector	MD Howard 10e. Street and Number		Columbi			1	l0g. Citizen of What C	1 ☐ Yes 2 No
DESILIMOTE, INICITY ICID A 12.15-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural" or Items 23a or 28a-1 show any nighty or other traumatic event, the Modical Examinations at any once.	by Funeral Director	11. Marital Status 1□ Never Married 2□ Married 3♥ Widowed 4□ Divorced	12. Was Decedent Armed Forces? 1 12 Yes 2 1 If Yes, Give Year or Dates:	NO 0N	3. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp. n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	United Sta 14. Race - Arr Black, Wh Specify: Whi	erican Indian, ite, etc.
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mit. Pages 1 and 2 pertment of Health a portant: If item 27 is y injury or other tra		Mr. James Nimmo/ 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Species)	Removal from State	20b. Place of Di cemetery, o	4 Eagan Dri sposition (Name of crematory or other place eake Cremat	9)	Date Jun 9	32822 20c.Location - City o Beltsville	
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Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	a. Su Due to (or as		hemato	ma amada a		7:	Onset and Death UNKnown
od/ou, ificate be executed g physician and as the burial-transit	edical Exa	that initiated events resulting in death) Last	Due to (or as	a consequence of):				IER M	
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ding Phys h. After this funeral di	ertification; To B	examinar? 1 Per 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Day	y Year) Inju	e of 28c. Injury Work	r. 4 🗆 Nursing Ho	me 5 Reside 28d. Describe ho	ence 6 Other (Spoow injury occurred	
UNISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	O	3 Suicide 6 Could not 4 Homicide determined	building, etc.	of my knowledge, d	eath occur d at the time	e, date and place,	3221 A	ause(s) and manner a	e Blvd Silvers
To the Howithin 24 To tha Fu	Medical	29b. Signature and title of certifier	वार्षं तिवासामः अस	100.	29c. License	number	2	ate and place, and du	th, Day, Year)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Month Year Kobinsor 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Jown, or Location of Death 4c. County of Death Examiner , MOLL DAN 5. Social Security Number Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Min. Hours Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location ehow. 10d. Inside City Limits Item 27 is marked other then "natural", or Items 23a or 28a-f ebov other treumatic event, the Madical Examplar must be notified at Baltimore IND 1 ☐ Yes 2 🗹 No **Funeral Director** 10g. Citizen of What Country? 10e, Street and Number . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cylban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No lf Yes, Give Year or Dates: Specify Be Completed by 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry it. Pages 1 and 2 should be filed withir infenent of Health and Mental Hygiene.

rrant: if Item 27 is marked other then njury or othar treumatic event, the Na xlamtress 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State nod of Disposition 1 Burial 2 Cremation 3 Removal from State Important: If eny Injury o once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee permit. 22. Name and Address of Facility Vaughn 23a. Part1. Enter the distance, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** days /Medical Due to (or as a consequence of) Examiner Kidne MYOMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner hysicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 phys use as IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f 9 Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 Onknown 1 ☐ Yes 2 ∏ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 2 1 No 1 Yes To the Hospitel or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 1 Tes 2 No Medical Certification; To 1 / Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury within 24 hours after death.

To the Funerel Director; All completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 8,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loca N. Weife St Johns Hockins Hospital Tower 110 Dector's Lounge 5 MD Jarrard Julia Balhmare, MD 21287 2. Registrar's Signature 31. Date filed (Month Day 2004 State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/200

Registrar

			T= For State Registrar	State of Maryl	and / Depa	artment of F	lealth and Death	d Mental Hy	giene Reg. No. 20 () 4 18	345
	Physici		Decedent's Name (First, Middle, Last) Virginia	L. Robin	son	 		2. Date of De June	8 ^{pay} 200	3. Time of 3:35	
E	/Medic Examin		4a. Fecility Name (If not institution, give Stella Maris			4b. City, Town, o Baltimo			4c. County of		
	Funeral Director		217 10 0003	7. Age (In)	rs. last birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 H	Jan • 2	th, Year 27 M	B. Birthplace (State of Country) [aryland	r Foreign
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	with the	Funeral Director	10e. Street and Number 1351 South Clin	Ap	t. 302	10f. Zip Code	.224		10g. Citizen of Wh	at Country?	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heatth and Mental Hygiene. If flem 27 is marked other then "naturel", or flems 23a or 28a-f show or other traumatic event. It a Medical Examinating the notified at	۵	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Midowed 4 ☐ Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No ento Rican, etc.)		American Indian, White, etc. White	
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land 2	should be filed and Mental Hygin s marked other umatic event.	To Be Co	17. Father's Name (First, Middle, Last) John Dudek				18. Mother's N	Name (First, Middle,	, Maiden Sumame)		
Mary	1 and 2 shou Heatth and N em 27 Is mai		19a. Informant's Name/Relationship (Ty) Rita Woody (dau				and Number or	Rural Route Number	er, City or Town, St.		
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			30. Name and address of person who co P. Ledakis, M.	D. 301 St	. Paul		altimo	ore, Mar	yland 2	1202	
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/B // a - d : -			Eileen P. Roma	nek	Month M	ay 30, 2004 ^{Year}	11:10p
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neral ector		469.24.2054	744 - 20 -	rthday) If Under 1 Year If Under 24 Hr Yrs. Months Days Hours Mir		v, Year) Cour	olece (State or Fo ntry) Minnesota
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rat be n	al Dire	10e. Street and Number 7147 Smooth Path		10f. Zip Code 21045		10g. Citizen of What Cour U.S	-
in tem 2/ is marked other than natural, or tems 29s or coars snow or other treumstic event, the Medical Examiner must be notified at	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No into Rican, etc.)	14. Race - Americ Black, White, Specify:	
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E E E		19a. Informant's Name/Relationship (7	· · · · ·	 Mailing Address (Street and Number or F 1710 Bennett Road Eldel 			Code)
other 1	-	Ms. Suzanne Bolanc	20b. Place o	f Disposition (Name of	Date	20c. Location - City or To	own, State
Importent: If item 27 any injury or other tr <u>once</u> .		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Hemovai from State	nty Crematory or other place) to Cremation Services! Inc.	4.	Sykesville,	
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State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year RIDDLE **Physician** TOHN 4.45 TUNE 2004 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL HOWARD COUNTY HOWARN COLUNBIA If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours 212.36.915 68 ì M 2□ F Yrs. January 11, 1936 Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location or 28e-f show the Medical Examiner must be notified at Woodstock 1 ☐ Yes 2 No Maryland **Baltimore** Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21163 U.S.A. 10370 Rt. 99 Items 23a permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or thems 23a any injury or other treumatic event. It a Medical Factorial process. Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 White Specify. δ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Construction Elementary/Secondary (0-12) UNKNOWN College (1-4or 5+) **Business Owner** 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frank Riddle Mazie Aleshire ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10370 Rt. 99 Woodstock, Maryland 21163 Ms. Mary Lou Riddle Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 06/05/2004 Marriottsville, Maryland Mt. View Cemetery ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A. 21. Sign were Truneral Service License 3871 Old Columbia Pike Ellicott City, MD 21043 1100570 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disea, e or condition resulting in death) MULTIPLE ORGAN FAILURE Physician /Medical Due to (or as a consequence of): **Examiner** INFARCTION MYOCARDIAL Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Attending Physicien: The law requires that the death certificate be executed CARCINSMA Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 DISEASE CHRONIC PULNONARY by Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 2 Fetal death 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 √Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No us after death.
us after death.
us after death.
'n by the funeral director, pa 2 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1_Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospitel within 24 hours a To the Funerel E Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ATTENDING PHYSICIAN DUD56948 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CLOUD LEAD TANSINDA 8775 COURT COLUMBIA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar IUN 1 0 2004

State of Maryland / Department of Health and Mental Hygiene 2004

18348

								Cen	iticat	e or	Death			Reg. N	lo.			
	Physicia	n	1. Decedent's Name (First, Middle, Last) Mary Montgomery Sauerwein									2. Dete of D Month)ay	Year	3. Time of		
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	and and	ł	Usual Residence of Deced 10a. State 10b.	County		100	. City, Town	or Loca	ation							1	0d. Inside Cit	v Limits
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	be filed within 72 hours efter death with the Meryland ital Hygiene. d other than "natural", or flems 23a or 28a-f show event, the Medical Examinar must be notified at	Completed by Funeral Director	11. Marital Status		12. Was De	cedent Ever	in U,S.	13. W	<u> </u>		lispanic Ori	igin? (Sp	ecify Yes or N Rican, etc.)	0-	14. Rac	e - Americ	an Indian,	
_	fler of the control o	ᆵ	1 Never Merried 2	☐ Married	Armed F 1 ☐ Yes	2 No							Rican, etc.)		Blac	ck, White,	_{etc.} nite	
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	日本なた		Charles H.	Saue	rwein,						dale I)r.,	Mt. Ai	ry,	MD.	2177	1	
ore	es 1 en of Heal f item 2 r other		20a. Method of Disposition 1 X Burial 2 ☐ Cren		□ Ramoval from	0	b. Place of cemetery	, creme	story or o	ther pla		1	Date			City or To		_
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Baltimore,	permit. Pages 1 Depertment of H important: If ite any injury or ot once.		21. Signature of Funeral S	ervice Lice	nsee			22.	Name an	d Addre	ss of Facili	y Lou	ıdon Pa	rk :	Funer	al H	ome	
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Ö	s effe Dira	Certification:	4 Homicide		bullo	ling, etc. (Sp	өсіту)						City or To	WII, SIA	(0)			
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	To the Hospital or Attendi within 24 hours effer death. To the Funeral Director: A completely filled in by the t	edicai	(Check only 2 M	oulual EXA	miner: On the t and mar	nner stated.	ination and	or Inve				ui occurr	ou at the time,	uate al	id place, a	and due to	une cause(s)	
	With Totl com	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month) 30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) Ramach Cabapath 3400 Erdman Mence Balaman Many							(Month, I	Dey, Year)	_							
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		A	MEND ITEM #1 PER P	HY G832 6/10		•		-	Reg. No. 2	004	18349
	Physici	an	Decedent's Name (First, Middle, Les.	KOBERT SI	ELTON	JR		2. Dete of De Month	Dey	Year	3. Time of Death
1	/Medi	cal	4e Fecility Neme (If not institution, give	street and number)	IK.		4b. City, Town, or L			1004	7:04
and the	Examir	ier	VA Medical				BALTII		4c. County	OI Deetii	
	Funeral	4	5. Social Security Number 6. Se	x 7. Age (In	yrs. lest birt	hday) If Under 1 Ye	ear If Under 24 Hrs.		th 25,1937	9. Birthple	ace (State or Foreign
2.2	Director		235-54-3286 Usuel Residence of Decedent	ØM 2□F 6	7 .	Yrs. Months Da	ys Hours Min.	March	29;1937	Wes	Virginia
	Mend Mend		10a. State 10b. County	100	. City, Towr	or Location				10	d. Inside City Limits
	th with the Merylen 23s or 28s-f show ust be notified at	ctor	Maryland		Balti	more					1Ã Yes 2 ☐ No
	or 28	Director	10e. Street end Number			10f. Zip Cod			10g. Citizen of		ry?
	ath w	rall	3436 Chesterfield				1213		U.S		
Maryland 21215-0020	72 hours efter death with the Meryland natural', or items 23a or 28a-f show dieal Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ◯ vivorced	12. Was Decedent Ever Armed Forces? 1 1 Yes 2 □ No If Yes, Give Year or Dates:	in U,S.	13. Was Decedent If Yes, specify 0 1 □ Yes 2 1	of Hispanic Origin? (Sp Cuban, Mexican, Puerto No <i>Specify:</i>	Decity Yes or No Di Rican, etc.)	Specify	ce - America ck, White, el	tc.
5-0	72 ho	eted	15. Decedent's Edu (Specify only highest gred		16e.	Decedent's Usual Oc (Give kind of work do	cupation one during most of work tired)	king	16b. Kind of B	usiness/Indu	ustry
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lan	Mental Mental arked o	o Be	Robert Jordan She	elton			Estel	la Floo	d	,	
ary	should be should	-	19a. Informant's Name/Relationship (T	ype, Print)		_	eet and Number or Rui			Stete, Zip (Code)
	end 2 ealth n 27 i		Donna Jones - sist				Westminst				
Baltimore,	nit. Pages 1 er bertment of Hea ortant: if item 2 Injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ 1 ☐ 2 ☐ 1 ☐ 2 ☐ 2 ☐ 2 ☐ 2 ☐ 2 ☐ 2 ☐	Removal from State	cemeter	Disposition (Name of y, crematory or other Crematoy	place)	Date 12, 2004	Baltin		
Bal	permit. P Depertm Importar eny Injur		21. Signature of Funeral Service Licens	ee		22. Name and Ad Eckhardt 11605 Rei	dress of Facility Funeral Ch sterstown	apel P. Rd. Owi	A. ngs Mil:	ls, Mc	l. 21117
44			23a. Pert1. Enter the diseese, or comp shock, or heart failure. List only o	lications that caused the one cause on each line.	death. Do n	ot enter the mode of	dying, such as cardiac	or respiratory ar	rest,	; li	Approximate Interval Between
Y.	Physician /Medical		Immediate Cause (Final	0.00	a AT	-0	0.71.00				Onset and Death
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68760,	ficete phys s the	Medical	that initiated events resulting in death) Lest	Due t	o (or as a co	onsequence of):					
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9	death ce e ettendi ed for use	sicia	Part II. Other significant conditions con	ntributing to death but not	resulting in	the underlying ceuse	given in Part I.	23b. Did t	obecco use co	ntribute to t	the cause of death?
P.O. Box	v requires thet the death cer been signed by the ettendir should be deteched for use	Physician/N				, ,		101	Yes 2□ No	3 Proba	ubly 4 Unknown
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<u>></u>	Physician: rthis certific ral director,	ToB	examiner? 1 □ Yes 2 No	Hospitel: 1 Inpatient	2 🗆 ER/Out	petient 3 DOA	Other:		lence 6 Oth	er (Specify)	
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Division	Attending or deeth. ector: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Piece of Injury - A	At home for		☐ Yes 2☐ No	28f Location (S	Street and Numb	or or Pural I	Pouto Number
<u>></u>	effer Direction by	Certification:	4 ☐ Homicide determined	building, etc. (Sp		in, street, lactory, on		City or Tow	m, State)	SI OI FIDIOI F	TODIO NOTIDOS,
	To the Mospital or Attending Physician: The is within 24 hours effect death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) 12 Certifying Physical Exami	sician: To the best of my ner: On the basis of exan and menner stated.	knowledge, nination and	death occurred at the Vor investigation, in m	time, date and place, y opinion, death occurr	and due to the cred at the time, c	cause(s) and ma date and place, a	nner as stat and due to th	ed. he cause(s)
	To the To the complete	M	29b. Signature and title of certifier				ense number	1	29d. Date signed		
			Motor flor	ms		- Tanga	5100		June	8,	2004
			30. Name and eddress of person who co	FLAMMER	< m	Type, Print)	5100 0 N. G.	REENE	ST.	BALT	Timore, MD
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrer's S	ignature	Londo					

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Walter Smith 2004 /Medical Fecility Name (If not institution, give street and number) City, Town, or Location of Death County of Death Examiner Kosedale
If Under 1 Year | If Under 24 Hrs. sare more 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F Yrs. Baltimore, MD **Director** October 1 214 20 6146 78 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r than "natural", or items 23a or 28e-f shov The Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1509 Cavel Road 21237 USA Funeral or items 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔼 No Specify: Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) WA Elementary/Secondary (0-12) Shipping Manager National Brewing Co. other 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other treumatic event, sing. 17. Father's Name (First, Middle, Last) Be Mary Lipka John Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice E Smith (Wife) 1509 Cavel Road Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cem. June 10 2004 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Less on Fine al Hime Inc 7401 Belair koen Baltimore, Maryland 21236 Part 1. Enter the disease, or complications is a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer with liver Metastatic · Metastatic Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Yes 20 No 1 Tyes Division of Vital To the Hospitel or Attanding Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? After Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. M ☐ Accident after death 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 THomicide within 24 hours a To the Funerel (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Kesooo

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUN 1 0 2004

Square Drive,

cause of death (Item 23a) (Type, Print)

Jole Palem 4000 ar) S2. Registrar's Signatus

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Marie F. Schisler June 9:30 A.M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3016 Indiana Avenue Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Year)
June 11, 1 9. Birthplace (State or Foreign **Funeral** Days Hours 218 14 0727 79 June 1924 Mary1and Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits ed other than "natural", or Itams 23a or 28a-f show event, the Wedical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3016 Indiana Avenue 21227 U.S. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White à 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) fited within Hygiene. permit. Pages 1 and 2 should be fited wit Department of Health and Mental Hygiens Important: If Itam 27 is marked other than any injury or other traumatic event, that once. Optic Book Bindery Master Book Binder 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bernard Bull Marie Newton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn Sawyer / Daughter 3016 Indiana Avenue Baltimore, Maryland 21227 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Bayview Crematory 6/9/2004 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 ecome manucacula 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician Seviner /Medical resulting in death) Due to (or as a consequence of): months Examiner Sequentially list conditions, if any, beauing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to (or as a nonsequence of) Examiner the death certificate be executed and Due to (or as a consequence of): the attending physician a ned for use as the burial-Box 68760. Physician/Medical the t as IE EEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) P.O. I signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? Records, à 1 ☐ Yes 2 ☐ √No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed page 413/00 this certificate Division of Vital 1 Yes 2 XNo 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) ٩ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident Injury 5 Pending within 24 hours after

To the Funeral Director: After 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 127541 June 4,2-004 (reeman Lega MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimone MD. 21227 Rel 4067 Helling Fern RAJA. CLEGTHA IVII 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUN 1 0 2004

DONALD N STANSFIELD MHW

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of <i>rtificate of</i>		/lental H		ne No 200	4 18352
Phys /Me	ician dical	Decedent's Name (First, Middle,	Donald No	rris Stansf	eld		2. Date of Month JUNE	(Day Y	3. Time of Death 6:58 A M
Exan	niner	4a. Facility Name (If not institution, 10122 CENTURY I	DRIVE		ELLIC	or Location of Death OTT CITY If Under 24 Hrs.			4c. County of I	Death RD CO
Funer		5. Social Security Number 217-74-4159 Usual Residence of Decedent	1. Sex 7. Ag	e (In yrs. last birthday, 48 Yrs.	Months Days		8. Date of (Month, Octobe			Birthplace (State or Foreign Country) Maryland
death with the Maryland ms 23a or 28a-f show	ctor	10a. State 10b. County Maryland	Howard	10c. City, Town or L		Ellicott City				10d. Inside City Limits 1 ☐ Yes 2 No
ath with th 23a or 28	rai Director	10e. Street and Number 10122 Century Drive			10f. Zip Code	21042		10g.	Citizen of Wha	t Country? U.S.A.
it 6	d by Funeral	11. Marijal Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 M If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or Rican, etc.)	No-		American Indian, White, etc. White
Maryland 21215-0036 to 2 should be filed within 72 hours aft and Mental Hygiene. 27 Is marked other than "natural", or traumatic event, the Medical Evanti	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or	(Give	DO NOT use retin	a during most of work	ring	16b.	Kind of Busin A	ess/Industry .utomotive
Waryland 2121 12 should be filed within h and Mental Hygione 7 is marked other than " traumatic event, the Men	To Be C		E. Stansfield			18. Mother's Nam		Ruth	G. Galley	
and 2 sh ealth and m 27 is m		19a. Informant's Name/Relationshi Ms. Betty Taylo		er	1183 Norhur	st Way North	Catonsvil	le, Ma	ryland 212	228
Baltimore, Miparmit. Pages 1 and 2 Department of Health a important: If item 27 is any injury or other tra		20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	cify)	All County C	remation Se	ervices, Inc. ⁰⁶	Date /10/2004			y or Town, State ville, Maryland
Darmit Depart Impor	SUCE	21. Signature of Funeral Sirvica Li	cher moi	293	3871	Funeral Home Old Columbia	Pike Ellic		ty, MD 21	043
Physicia /Medica Examine	il r	23a. Part1. Enter the disease, of o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. CORON Due to (or as	a consequence of):			or respiratory	/ arrest,		Approximate Interval Between Onset and Death
Box 68760, Sideath certificate be executed eathending physician and office use as the burial-transit.	dical Examin	Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
BOX (death certification of the use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnand Other (specify)	cy			23d. Date of Month	delivery Day Year
cords, P.O w requires that the been signad by th should ba detache	ed by Pi	Part II. Other significant condition	s contributing to death b	ut not resulting in the u	nderlying cause gr	ven in Part I.				e to the cause of death? Probably 4 Unknown
I Rec Tha law ate has b	Completed							topsy rformed?	prior deatl	e autopsy findings available to completion of cause of n? les 2 \(\text{No} \)
of Vital Ro Physician: Tha this certificate hir	o Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	ent 2 EP/Outpatier	t 3□ DOA Ot	26. Place of Death	-		6 Nother (S	Specify) SCENE
on o	Certification; T									
Divisit To the Hospital or Attent within 24 hours after death To the Funeral Diractor: completely filled in by the		4 Homicide determin	building, et	c. (Specify) of my knowledge, deat	occurred at the t	ime, date and place,	City or 7	own, Sta	(s) and manner	r as stated
To the Hospital within 24 hours a To the Funeral I	Medical	(Check only 2X Medical Ex	aminer: On the basis of and manner sta	f examination and/or in	estigation, in my	opinion, death occur	red at the time	e, date a	nd place, and	due to the cause(s)
To With	4	29b. Signature and title of certifier	One You	e un		C M E			UNE 5,	onth, Day, Year) 2004
8	tate	30. Name and address of person with Alfraga A. 31. Date filed (Month, Day, Year)	MORELL	eath (Item 23a) (Type, ar's Signature		enn Stree	t, Bal	timo	ore, Ma	ryland 21201

JUN 1 0 2004

			1 - For State Registrar	State of Maryland	d / Depa <i>Cer</i>	artment o tificate	of Hea	alth and eath		giene Reg. No. 200	4 18353	
	Physici /Medi		1. Decedent's Name <i>(First, Middle, Last)</i> Florence Ela						2. Date of De Month June	8, 2002	3. Time of Death 8:55 P M	
	Examir		4a. Fecility Name (If not institution, give Brighton Gardens			Tow	son	cation of Dea			imore	
	Funeral Director		5. Social Security Number 6. Security Number 451-10-3037	7. Age (In yrs. I.		If Under 1 Y		Under 24 Hr. Hours Mir		y, Year)	Birthplace (State or Foreign Country) Texas	
	the Maryland 28a-f ehow	Director	10a. State 10b. County Maryland Baltimore		, Town or Lo	cation	nda .			10g. Citizen of What	10d. Inside City Limits 1 Yes 2 No	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Itams 23a or 28a-f ehow or other traumatic event, the Medical Examinar must be noutiled at	by Funeral DI	6451 North Charles	S Street 12. Was Decedent Ever in U.: Armed Forces? 1 □ Yes 3 □ No If Yes, Give Year or Dates:		2	21212 t of Hispa Cuban, N		Specify Yes or No rto Rican, etc.)	USA	merican Indian,	
21215-0036	within 72 hour ene. than "natural he Madical Ex	Completed to	15. Decedent's Edu (Specify only highest grade	cation e completed) College (1-4or 5+)	(Give	ent's Usual O kind of work o OO NOT use r	done duri retired)		orking	16b. Kind of Busine	ss/Industry	
Maryland 2	2 should be filed vand Mental Hygie is marked other traumatic event, the	Be	17. Father's Name (First, Middle, Last) Matt L. Corley	2		Homema			ence Bush	Own Hor	ne	
e, Mar	I and 2 she fealth and im 27 is m ther traum		19a. Informant's Name/Relationship (Ty). Judith McFadden/Da	aughter	1423 F		enue		more, MD			
Baltimore,	permit. Pages 1 Department of t- Important: If its any injury or ot		20a. Method of Disposition 1 ☐ Burial ※☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Met	metery, crem ro Cre	ematory or other	r piace) 7 Inc		Date 9-04	20c. Location - City Baltimo		
Ba	Depa Impo any ii		21. Signature of Funeral Service License Thomas Gregor 23a. Part 1. Enter the disease, or compli		Cr 29	Name and A emation 9 Fred	n Sc leric	ciety k_Roac	Of MD. I Baltimo	nc. re, MD 212	228 Approximate	
***	Physician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ALTHE MERS TYPE Due to (or as a consequence of):									
8760,	death certificate be executed estending physician and estending physician and ad for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ								
P.O. Box 6	death certif e attending id for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnar 1 Live birth 2 Fetel 4 Pregnant at time of de	death 3 🗌	Ectopic pregn Other (specif				23d. Date of d Month	lelivery Day Year	
	The law requires that the de ste has been signed by the bage 2 should be detached		Part II. Other significant conditions con	RY MREM		derlying caus	e given ir	Part I.	23e. Did to	1	to the cause of death? Probably 4 Unknown	
al Reco	2 2 2	Completed by	ATRIAL FIRRILL	-ATION	-				24a. Was a autop perfor	sy prior to med? death?		
Division of Vital Records,	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	tion: To Be	27. Manner of Death 1 Kanatural 5 Pending	-	R/Outpatient 28b. Time of Injury	28c.	Other: Injury at Work?			ne) ence 6 XOther (Sp ow injury occurred	Assisted Decity) Living	
Divisi	To the Hospital or Attend within 24 hours after death To the Funeral Director: K completely filled in by the fi	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,			-	2 🗔 140	28f. Location (S City or Tow	treet and Number or I n, State)	Rural Route Number,	
	To the Hospital within 24 hours a To the Funeral I completely filled	edical C	29a. Certifier (Check only one) 1 S. Certifying Phys 2 Medical Examin	ician: To the best of my know ler: On the basis of examinati and manner stated.	rledge, death on and/or inve	occurred at the estigation, in r	ne time, o my opinio	late and place n, death occi	e, and due to the curred at the time, o	ause(s) and manner a late and place, and di	as stated. ue to the cause(s)	
)	To the Complex	Σ	29b. Signature and title of certifier MASTAL	Mo			30	+ 33		9d. Date signed (Mor		
_	b.		30. Name and address of person who come M DHLY M1 CM	BMC 6701	NO	CHARL	ES	81	BAU	Inorc	MO 21204	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire don	Shel						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2004 **Physician** June 6, 10:45 p M Shirley Taylor /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Catonsville Commons Nursing Home Catonsville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Min. | March 22, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M 2∰F 1917 West Virginia 214-50-3553 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If len 27 is marked other than "natural" or the any injury or other trainment. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State and Mental Hygiene.
Is marked other than "natural", or items 23s or 28s-1 show is marked other than "natural", or items 23s or 28s-1 show raumatic event, the Madical Examinar mast be notified at 1 ☐ Yes 2 No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 USA 4110 Frederick Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□Yes 2□No Specify: White white þ 3℃Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Calvin Hamrick Nettie May Dyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Maurice D. Taylor- son 4110 Frederick Ave. Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery June 10, 04 Baltimore Maryland * 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Loudon Park Funeral Home angi 3620 Wilkens Ave. Baltimore, MD 21229 23a. P. rt1. Enter the disease, or complications of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dement /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause that he donying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 Inpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Mann of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of To the Funeral Director: After completely filled in by the funer Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sonte 308 13alf. MD 2120 1 HASHONI Zn 821 NI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004. 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 815 P **Physician** Dallace JUDE مان 2004 IRainia /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Stella Maristospice angecy 5. Social Security Number 6. Sex 7. Age BA (In yrs last birthday) DALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 F Months 217-18-3823 Usual Residence of Decedent Director 10c. City, Town or Location 10d. Inside City Limits 10b County 10a. State perrait. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23e or 28e-f show any nigury or other traumatic event, Ira Madical Examilier is usi be neithed at once. 1 ☐ Yes 2 No BALTIMORE **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1608 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Race - American Indian, Black, White, etc. 11, Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FRICERICK 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a_Informant's Name/Relationship 2300€ MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition

Burial 2 Cremation Date 20c ocation - City or Town, State 3 Removal from State -04 `4 Donation 5 Other (Specify) BALTIMORE, MD 21234. 21. Signature of Funeral Service Lic 22. Name and Address of Facility EVANS FUNERALCHAPEL, 8800 HARFORD RD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Pigal disease or condition resulting in death) NS ON'S **Physician** CY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Observe or narry that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 2 No 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) hospice 2 ER/Outpatient 3 DOA Certification: To 1 🗌 Yes 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 07930 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Foldman 301 Baltimore 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

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			Registrar	2.0	Reg. No. UUS Date of Death Wonth Day Year	3. Time of Death
	Physici /Medic	al	Lante L. WILSON		UNE 8, 2004 4c. County of Dea	1:20p M
1	Examin		4a. Facility Name (If not institution, give street and number) NEAR 6421 MEADOW BRIDGE ROAD	EDEN	WORCESTE	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min.	Date of Birth 9. Bir	hplace (State or Foreign
	pu *	0	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or L.	ocation		10d. Inside City Limits
	the Marylan 28e-f show	ctor		nore		1 Yes 2 □ No
	.≘ o ≥	Director	10e. Street and Number 2(01 E: Nbrdban Park, nu	10f. Zip Code 21214	10g. Citizen of What Co	ountry?
	ter death w Items 23e	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricar	Yes or No- n, etc.) 14. Race - Ame Black, Whit	
980	urs atte el', or It Examin	by	1 ☐ Yes 2 ☐ No 1 ☐ Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 K No Specify:	Specify: B	lack
15-0036		Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of working DO NDT use retired)	16b. Kind of Business	Industry
2121	ed withii giene. er than	Comp	Elementary/Secondary (0-12) Gollege (1-4or 5+) CU	Mh Super visor	- Dept. OFS	cial Service
and	2 should ba filed withir and Mental Hygiene. Is marked other than aumatic event, I'R M.	To Be	Father's Name (First, Middle, Last) (Father)	18. Mother's Name (Fin	st, Middle, Maiden Sumame)	
Maryland	ges 1 and 2 should be filed within 72 h t of Health and Mental Hygiene. If item 27 Is marked other than "natu or other traumatic event, I'm M. Jic.	۲	19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ling Address (Street and Number or Rural Ro	ute Number, City or Town, State, .	DIAG M
	permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other try once.	{	20a. Nethol of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Dis	Walden Laurel Osition (Name of Date	20c. Location - City or	7 2120 1 Town, State
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Ball	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	7 marketis OF Treene	Balto ND 2	ervices
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Вох	eath certific attending p	by Physician/Me	In the past 12 months?	□Ectopic pregnancy □ Other (specify)	23d. Date of de Month	ivery Day Year
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Division of Vital Records, P.O.	uires that the de signed by the a id be detached f	d by F	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacco use contribute to 1 ☐ Yes 2 🖄 o 3 ☐ Pt	o the cause of death?
ecor	law requir as been si 2 should l	Completed			24a. Was an 24b. Were at prior to	itopsy findings available completion of cause of
<u>a</u>	The reate har, page				performed? death? 1 Yes 2 No 1 Yes	
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Ö	pitel or ours aft ierel Di		FIELD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	PRECEO	City or Town, State) 6421 Meadow Brid	
	To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred at	the time, date and place, and due	to the cause(s)
	To To	Σ	29b. Signature and title of certifier	29c. License number OCME	JUNE 9, 2	
	2		30. Name and address of person who completed cause of death (Item 23a) (Type ANA RUBIO, MD 111			1001
	* Sta	ate	31. Date filed (Month, Day, Year) 22. Registrar's Signature	Penn Street, Baltim	ore, Maryland 2	1201
	Regist	rar	JUN 1 0 2004 Bentue 19	Spails		

			_ State	te of Maryland /	Department <i>Certificate</i>				iene g. N2 0 0 L	18357
			1. Decedent's Name (First, Middle, Last)	1				2. Date of Deat	-	3. Time of Death
	Physici /Medic			enry E. Winch				June	4. 2004	1:30 P. M.
	Examir	er	4a. Facility Name (If not institution, give street a				Location of Death		4c. County of Dea	
			North Arundel Hospit 5. Social Security Number 6. Sex	7. Age (In yrs. last bi	rthday) If Under 1		Burnie If Under 24 Hrs.	8. Date of Birth (Month, Day,	Anne A	rundel rthplace (State or Foreign ountry)
	Funeral Director		219-18-0910 1çm 2	□F 79	Yrs. Months	Days	Hours Min.			ountry) arvland
	Р >		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	vn or Location					10d. Inside City Limits
	faryla shov	ច			in or coodion		C1 5			1 ☐ Yes 2 🗗 No
1	ith the Marylan or 28e-f show	Director	Maryland Anne Aru 10e. Street and Number	indel	10f. Zip (Code	Glen Bur		0g. Citizen of What C	ountry?
d	h with		929 Sunny Brook Dri	.ve			21060		United S	tates
W,	ama 2	Funeral	Arr	s Decedent Ever in U.S. ned Forces?	13. Was Decede	ent of His	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
8	15-0036 72 hours after death with the Maryland "natural", or Itama 23a or 28e-f show catal Examinar must be mullied at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ If Y 3 ☐ Wildowed 4 ☑ Divorced Ye]Yes 2 □ No es, Give ar or Dates: WWII	1 ☐ Yes 2	⊠ No	Specify:		Specify:	White
45	21215-0036 d within 72 hours a giene. ar then "natural", o	ed b	15. Decedent's Education	168	. Decedent's Usual	Occupa	tion		16b. Kind of Business	s/Industry
3	215 Frin 73 99 " na	Completed	(Specify only highest grade comp	llege (1-4or 5+)	life. DO NOT use	k done di e retired)	uring most of work	ing	Clothing	
ž	d 2121 filed within Hygiene. whar then "	Con	10 Years		Cutter		18. Mother's Nam	- /Fire Adiable A	Manufactu	ring
WINCHESTE	aryland should be file and Mental Hy a marked oth numatic event	Be	17. Father's Name (First, Middle, Last) Henry Winchester					. VanMet	127	
2	shoutd nd Men marke	2	19a. Informant's Name/Relationship (Type, Pri	nt) 19	b. Mailing Address	(Street a			; City or Town, State,	Zip Code)
2	and 2 seath ar n 27 la		Mrs. Mary E. Vogt/		10229 Har	vest	Fields	Dr. Gra	anite, MD	21163
Y	altimore, Maryland 21215-0036 rmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla partment of Health and Mental Hygiene. portant: If tiem 27 la marked other then "natural", or Itema 23e or 28e-f shory injury or other traumatic event, the Modical Examinator must be rutillish at the.		20a. Method of Disposition 15 Burial 2 ☐ Cremation 3 ☐ Remova	cemete	of Disposition (Namery, crematory or other	e of her place		Date	20c. Location - City o	r Town, State
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光	Baltime permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee	MA		uck	s of Facility Funeral Ave. Du		Dundalk,	Inc. 21222
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	ires the signed to be d	þ	Part II. Other significant conditions contributions	1. A CAN	In the underlying ca	tuse give	nın raiti.	1 \(\text{Y}\)	· · · - ·	robably 4 Unknown
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	of Vital Rec Physician: The lav this certificate has	To B	examiner? 1 ☐ Yes 2 No Hospita	I: 1 Inpatient 2 ER/O	utpatient 3 DO	A Othe	or: 4 🗆 Nursing Ho		ence 6 Other (Sp	ecify)
	ing Pt			Month, Day Year) 28b.	Injury	Bc. Injury Work	.7	28d. Describe ho	ow injury occurred	
	Division of Vital Records, I or Attending Physician: The law requires that er death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Icati	2 Accident investigation 3 Suicide 6 Could not be	Place of Injury - At home	M M		res 2□No	28f. Location (St	reet and Number or F	Jural Route Number,
	Div A affer Direct Dire	Certification;	4 Homicide determined	Place of Injury - At home, building, etc. (Specify)	am, and al, radiory,	, 0,,,,,		City or Town		
	Division of Vital Rewarthe Hospitel or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	(Check only 2 Medical Examiner: O	To the best of my knowledgen the basis of examination and manner stated.	ge, death occurred a nd/or investigation,	at the tim in my op	e, date and place, inion, death occur	and due to the cared at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		29c.	License	number	2	9d. Date signed (Mor	th, Day, Year)
			Bolo	MD.		D4	3977		June 4	2004
	let 1		30. Name and address of Person who complete	and cause of death (Item 23a)	(Type, Print)	d,	Colon B1	mi,	mo. 2	196).
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Ann V	1				
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	Physic /Medi		1. Decedent's Name (First, M Lillia				Wrig	ıht				2. Date of E Month 6	eath 8	Day 2004	Year 1	3. Time of 10:p	Death M
	Exami		#a. Facility Name (If not instit Blue Point N	Г.Н.				E	Balti	Location of				4c. County	of Death		
	Funeral Director		5. Sociał Security Number 220–14–6765 Usual Residence of Deceden	6. Sex 1 M	2 X	78	last birthday) Yrs.	If Under Months	Days	If Under: Hours	Min.	8. Date of B	gy. 3	3 ")	9. Birthr	place (State or try)	Foreign
	Maryland I show	tor	10a. State 10b. Cou			10c. Cit	y, Town or Lo Balti								1	0d. Inside Cit	
	th with the 23a or 28a sal be nuti	al Direc	10e. Street and Number 322 Herring	Ct.				10f. Zip	Code 2123	l			10g	. Citizen of V USA	Vhat Cour	ntry?	
900	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Exact natural Secretified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 3 Widowed 4 Divor	Married	Was Deceder Armed Force; I ☐ Yes 2 ☐ If Yes, Give Year or Dates	No.		Was Deced f Yes, spec		spanic Origin, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or N Rican, etc.)	lo-		k, White,	ean Indian, etc. ack	
21215-0036	I within 72 h iene. r than "natu	ompleted	15. Dece (Specify only hi Elementary/Secondary (0-1 10th grade		on <i>mpleted)</i> College (1-4o	r 5+)	16a. Deced (Give life. L	kind of wor OO NOT us	l Occupa k done d e retired;	ition Juring most)	of worki	ing	16	Resta		,	
Maryland 2	ould be filed Menta! Hyg arked otha atic evant,	To Be C	17. Father's Name (First, Mid Preston	dle, Last)		Dupi					Hest			F.	lynn		
	and 2 shi ealth and n 27 Is m		19a. Informant's Name/Relate Melvine Turl		•	ece	503	L2 Win	ndso	r Mil						code)212 nore, M	
Baltimore,	Page nent c ant: If ury or		20a. Method of Disposition 1 ABurial 2 ☐ Cremati 14 ☐ Donation 5 ☐ Other		oval from Stat	•	lace of Dispo emetery, cren L. Ziol	_			c 6–12	-04		:. Location - ansdot	•		
Balt	permit. Pa Departmer Important any injury once.		21. Signature of Funeral Sen	rice Licensee	ane	_		. Name and arch				Balti 101 E.	moi No	ce, Md orth A	. 2.	1202	
8760,	Fryscian Addical Examiner /Medical Examiner the private fransit	Ilcal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfug Cause (Disease or injury that initiated events resulting in death) Last	a. A		s a consequ	usnea of):	16 (AK	4)101	/Asc	CULAT		Inser	tse.	Onset and Di	eath
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O E = 0 27 Manner of Death 28a Date of Injury 28h Time of									Othe	C HAMUR	sing Hor	(Check only ne 5 Res	idence			·)	
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	To tha Hospital or At within 24 hours after or To the Funaral Dirac completely filled in by	edical C	29a. Certifier Certific (Check only one)	fying Physicia cal Examiner:	n: To the bes On the basis and manner s	of examinat	wledge, death ion and/or inv	occurred a estigation,	t the time in my op	e, date and inion, death	place, a	ind due to the	cause	e(s) and man and place, a	ner as stand due to	ated. the cause(s)	
)	To th within To th compl	Me	29b. Signature and title of cer		alou	ran	(29c.	License) 2	number	5		/	Date signed	(Month, L	Day, Year)	
	4		30. Name and address of personal TASNEEM		HANI,	722	O PF	Print)	1/8	494	73	AVE,	1	3Ac	10 1	411212	08
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			For State Ragistrar	e of Maryland / [Department of F Certificate of	lealth and Mo <i>Death</i>	ental Hygid	ene 2004	18359
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Medi		Richard Elwoo		immerman			29, 2004	22:00 M
1	Examir	er	4a. Facility Name (If not institution, give street at 2413 Brohawn Avenue	nd number)		r Location of Death		4c. County of Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birt	hday) If Under 1 Year		8. Date of Birth (Month, Day, Y	9. Birthp	place (State or Foreign
	Director		(Unk) 1 📉 M 2 E	[]] 79	rrs. Months Days	Hours Min.	Jan. 1,	1925	place (State or Foreign http) Ohio
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location			1	0d. Inside City Limits
	th with the Marylar 23a or 28a-f show ust be notified at	tor	Maryland Maryland		Balt	imore			1 X Yes 2 □ No
	ith the or 284	Director	10e. Street and Number	-	10f. Zip Code		10g	g. Citizen of What Cour	itry?
	s 23a	rail	2413 Brohawn Ave.			21223		United Sta	
36	72 hours after death with the Maryland natural', or items 23a or 28a-f show iteal Examinat must be notified at	by Funeral	1 Never Married 2 Married 1 1	Decedent Ever in U.S. ed Forces? Yes 2 No ss, Give r or Dates: WW II	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Origin? (Spec an, Mexican, Puerto F Specify:	effy Yes or No- lican, etc.)	14. Race - Americ Black, White, Specify: Wh	
9	n 72 hours "natural", edical En	ted	15. Decedent's Education	16a.	Decedent's Usual Occup	ation	16	6b. Kind of Business/Ind	
Maryland 21215-0036	@	Completed	(Specify only highest grade complete Elementary/Secondary (0-12) College College	erea) ege (1-4or 5+)	(Give kind of work done life. DO NOT use retired				
121	be filed withintal Hygiene.		17. Father's Name (First, Middle, Last)	5+	Research A	nalyst 18. Mother's Name		esearch Ope	erations
and	s 1 and 2 should be filed f Health and Mental Hygi item 27 is marked other other traumatic event, I	To Be		mmerman		Buena	(r irst, iviidule, ivia	Marshall	
ary	2 should and Men Is marke aumatic	-	19a. Informant's Name/Relationship (Type, Prin	t) 19b.	Mailing Address (Street		Route Number, C		Code)
Σ	s 1 and 2 of Health item 27 I		Mary Z. Darne / Daught	0.5	12 N. 36th			22213	
Baltimore,	iges 1 it of H : If iter or off		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal	HOILI State	Disposition (Name of y, crematory or other place			c. Location - City or To	
Ħ.	ury and		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Chesap	eake Cremat			Beltsville	e, MD
Ba	permit. Departr Imports eny inji		Stolet Kolumum		Rapp Funer 933 Gist A	ve., Silv	er Sprin	g,MD 209:	
	Physician		23a. Part1. Ehter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	that caused the death. Do no on each line. eriosclerotic					Approximate Interval Between Onset and Death
	/Medical Examiner		De	ue to (or as a consequence o	of):				
	الإسك	ner	Sequentially list conditions, if any, leading to immediate	ue to (or as a consequence o	f):				
	ecuted and transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
68760,	ficate be executed g physician and as the burial-transit	al E	Di	ue to (or as a consequence o	i):				
687	ficate physis the	edical	d						
P.O. Box	ath certi attending for use a	hysician/M	in the past 12 months?	s, outcome of pregnancy Live birth 2 ☐ Fetal death Pregnant at time of death Unknown	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delive Month	ry , Day Year
	w requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions contributing	to death but not resulting in	the underlying cause give	en in Part I.	23e. Did tobac	cco use contribute to th	e cause of death?
ords	equire en sig ould b						1 🗆 Yes	2 □ No 3 □ Proba	ably 4 XIUnknown
of Vital Records,	The lar ate has page 2	Completed					24a. Was an autopsy performer	d? prior to con death?	osy findings available inpletion of cause of 2 \square No
Vita	Physicien: Th this certificate al director, pag	Be	25. Was case referred to medical examiner? Hospital:		Othy	26. Place of Death	-		
		. To	27. Manner of Death 28a.	1 ☐ Inpatient 2 ☐ ER/Out Date of Injury 28b. Ti	me of 28c. Injury	4 □ Nursing Hom	e 5 ☐ Residenc ld. Describe how	e 6 Other (Specify	scene
ion	Attending Ph r death. ector: Atter th by the funeral	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) In	jury Worl M 1 ☐	<br Yes 2 □ No			
Division	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, fan building, etc. <i>(Specify)</i>	m, street, factory, office	28	If. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
	he Hospi in 24 hour he Funer pletely fill	edicai	29a. Certifier (Check only one) 1 Cartifying Physician: 1 2 Madical Examinar: On and	o the best of my knowledge, the basis of examination and manner stated.	death occurred at the tim Vor investigation, in my op	ne, date and place, an pinion, death occurred	d due to the caus at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)
	Your To t	Σ	29b. Signature and title of certifie		29c. License		29d.	Date signed (Month, D	Jay, Year)
			(Correm)			D.C.M.E.		May 30, 20	04
	6		30. Name and address of person who completed J. Laron Locke M.D	•	Type, Print) 111 Penn St	reet, Balt	imore, M	Maryland 21	201
ľ	Sta Registr			32. Registrar's Signature	Locals				

			1 - For State Registrar	State of Mary	-	artmen rtificat			nd M		giene	2001	1836		
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last) John Martin Andre 4a. Fecility Name (If not institution, give s			4b. City,	Town, or	Location of		2. Date of De Month June	Day 8	Year 2004 County of Deat	3. Time of Death 1:00p M		
	Funeral Director		5. Social Security Number 6. Sex	Apt. 115 7. Age (Ir	n yrs. last birthday) Yrs.	La If Under Months		If Under 2 Hours	Min.	8. Date of Bir (Month, De	th y, Year)	9. Birt	George's 9. Birthplece (State or Foreign Country) Mary 1 and		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar meat be notified at 00ce.	Be Completed by Funeral Director	Usual Residence of Decedent	10	Dc. City, Town or Lo	ocation				Aug 14	, 19	28 Ma:	ryland 10d. Inside City Limits 1☐Yes 2☐No		
			10e. Street and Number 501 Main Street Apt. 115 11. Marital Status 1 Never Married 2 Married 3 Widowed XXDivorced 10. Was Decedent Ever in U.S. Armed Forces? 1 Yes. 22 No If Yes. Give Year or Dates:										Citizen of What Country? S.A. 14. Race - American Indian, Black, White, etc. Specify: White		
			15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	eation	16a. Dece (Give life.		al Occupa rk done d se retired,	uring most		og (First, Middle,	16b. Ki	nd of Business/	Industry		
	2 should be and Menta Is marked aumatic ev	ToB	Francis Andrews Pauline Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,								r Town, State, Z	Tip Code)			
	ages 1 and of Health it of Hem 27 or other tr		John M. Andrews, 3 20a. Method of Disposition 1 □ Burial 2 ☑Cremation 3 □ Ro	emoval from State	10130 20b. Place of Dispo cemetery, crei	osition (Nar matory or o	ne of ther place)	Da	ate		aryland cation · City or	21046 Town, State		
Baltin	permit. Pa Departmen Important any injury once.		*4□Donation 5□Other (Specify) West Arundel Crematory 6/9/2004 Odenton, Maryland 21. Signature of Funeral Service Licensee Bonarian Address of Funeral Home, P.A. / M00770 313 Talbott Avenue Laurel, Maryland 20707												
	Physician /Medical	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a Coronary Artery Disease									, Tana	Approximate Interval Between Onset and Death Years			
of Vital Records, P.O. Box 68760,	death certificate be executed be extended by a strength of the control of the con	tion; To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Hyperten Due to (or as a co Hyperlip Due to (or as a co Diabetes	ridemia onsequence of):								Years Years		
	death certific e attending p id for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 8 \(\text{Unknown} \)	1 Live plan 2! Felal death 3! Inclopic pregnancy								3d. Date of deli Month	very Day Year		
	ysician: The law requires is certificate has been sign director, page 2 should be		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the underlying cause given in Part I.												
										1 ☐ Yes	sy rmed? 2 ⊠ X o	24b. Were au prior to death? 1 \(\text{Yes}	topsy findings available ompletion of cause of		
			27. Manner of Death XXNatural 5 □ Pending	26. Place of Death (Check only one) Ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (3 Nursing Home 5 Residence 6 Other (3 Nursing Home 5 Nursing Home 5 Residence 6 Other (3 Nursing Home 5 Nursing Home 6 Nursing Home 6 Nursing Home 6 Nursing Home 6 Nursing Home 6 Nursing Home 7 Nursing Home 8 Nursing Home 7 Nursing Home 8 Nur								ity)			
Division	afte Dir	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined							281. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospital or within 24 hours afte to the Funeral Director Completely filled in I	Medicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s								place, and due	to the cause(s)			
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8	Sta Registr		Raymond Banfer, MD 31. Date filed (Month, Day, Year)		rman Road			Mary	land	2072	3				

Funeral

Director

27 is marked other then "naturel", or Itams 23a or 28a-f show treumatic event, the Madical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Itan any injury or other treumatic event, the Madical Examinat

Physician

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Box 68760

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Records,

Division of Vital

/Medical

3altimore, Maryland 21215-0036

with the Maryland

death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2004 **Physician** Achinanya June 06, Bonaventure 1942 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore

Vear | | Under 24 Hrs. NA Harbor Hospital Date of Birth (Month, Day, Y 7-14-47 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days Birthplace (State or Foreign _Country) Months Hours 1X M 2□F 56 577-76-2040 -56-NIGERIA Vre Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Director Baltimore Md. NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5704 Maple Hill Rd. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Yes 2 No Black Specify: þ Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 6 Staff Specialist Rehabilitation State of Md. yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Achinanya Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fidelis Achinanya Brother 3508 Cascade Ave., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ALIKE -UMUNUMO,NIGERIA * 4 ☐ Donation 5 ☐ Other (Specify) 7/3/04 FAMILY PRIVATE PLOT 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. March F.H. East 2a 1101 E. North Ave. War 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Atteroscionation COMOIOVASCULDA TISCASO Due to (or as a consequence of): Sequentially list conditions, dry leading by nedlate cause. Enter Underlying Cause (Disease or injury Examiner Dire to (or as a nonsequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?/ yes 28 No 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. MINTE June 07, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

To the Hospital or Attending Physician: within 24 hours a To the Funerel I

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State Registrar 31. Date filed (Month, Day, Year) 2004

HARDOUM

14DREW 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

			For State Registrar	State of Maryla	-	artment of H		lental Hygie		4 18362
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
н	Physicia		Wanda	Lee	And	er501		Month	Day Yea 10 70	1 1 1 4 5 M
	/Medic		4a. Facility Name (If not institution, give si		11160		Location of Death		4c. County of De	
	Examin	er	Os coll 1	In Cen	No -		Stmin3	ter		i.A.
			5. Social Security Number 6. Sex	7 Age (In)	rs. last birthday		If Under 24 Hrs.	8. Date of Birth	9.6	Birthplace (State or Foreign
м	Funeral Director			м 2⊠F 59	Yrs.	Months Days	Hours Min.	Nov. 24.	ear)	Country)
9		1	Usual Residence of Decedent				11		1711 110	ar y zand
	land ow		10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
	Man i eh	ţō	Maryland Carroll	W	infield					1 ☐ Yes 2 ☑ No
	the	Director	10e. Street and Number			10f. Zip Code		10g	Citizen of What	Country?
	3a o		1771 Bloom Rd.			21157		111	nited St	ates
	Jeath The 2	era		2. Was Decedent Ever i	n U.S. 13.	Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	14. Race - A	merican Indian,
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ī	of Heali Item 2 other		20a. Method of Disposition		b. Place of Disp cemetery, cre	osition (Name of ematory or other place		Date 20	c. Location - City	or Town, Stete
E	Page lent c nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 1 ☑ Donation 5 ☐ Other (Specify)	Zi		hurch Cem		2004 We	stminste	er, MD
Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or ot		21. Signature of Funeral Service License	900	1			rrier-Que	en Funer	al Home & Crem
ä	Depa Impo any i		Joseph 1	Elin		1212 West	Old Libe	erty Rd. W	linfield:	, MD 21784
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			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	fir a.	0011 1110	mada			Onset and Death
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	ted nsit	ů u	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Fr. Dhe	se ma	<i>t</i> =				Soveral users
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9 x	ding se as	/Me	IF FEMALE:	3c. If yes, outcome of pro	egnancy				23d. Date of	delivery
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oro	w requir been si should	Completed						-		
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ita	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?					th (Check only one)		
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	h		30. Name and address of person who co			e, Print)	ninster		6/10/0	57
				more B	olva.	WEST	NIVI TE	MD	211	<i>)</i> '
	Sta	ate	31. Date filed (Month, Day, Year)	33. Registrar's S	Signature					
	Regist	rar	JUN 1 1 2004	Marine	H Br	rate)				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2001 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20<u>04</u> **Physician** Year Robert A. Berglund, Sr. June 10, 12:05 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner 2445 Snydersburg Road Hampstead Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar 12,1929 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours **№** M 2□ F Illinois 318-22-8040 Yrs Director 75 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified at OREs. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Hampstead 1 ☐ Yes 2 No Director Carroll Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2445 Snydersburg Road 21074 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ⊋Yes 2 □ No 1949− If Yes, Give Year or Dates: 1952 Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) NSA Security Officer 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sylvia Eade Frank Berglund ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia L. Berglund, wife 2445 Snydersburg Road, Hampstead, MD 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Hampstead, MD 06/15/2004 * 4 ☐ Donation 5 ☐ Other (Specify) Hampstead Cemetery MO0723 22. Name and Address of Facility Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer **Physician** OLON disease or condition resulting in death) Car /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and I-tran Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has 2 No 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Mannes of Death 28b. Time of 28d. Describe how injury occurred 1 Naturai 5 Pending Injury 1 Yes 2 No 2 Accident investigation To the Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) l in by I 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature and atle of certifie 29c. License number 29d. Date signed (Month, Day, Year) 26385 person who completed cause of death (Item 23a) (Type, Print) 2/8 washington Goldstem. 32. Registrar's Signature State Registrar

Perna 4a. Fecility Name Sun-Br 5. Social Security 244-40-2 Usual Residence 10a. State Maryland 10e. Street and Nr 120 Bur 11. Marital Status 1 Never Mar 3 Widowed (Spe Elementary/Sec 17. Father's Name Hillary 19a. Informant's N	at 142 of Decedent 10b. County Cecil Imber clin Road ried 2 Married 4 Divorced 15. Decedent's Edicify only highest gracondary (0-12) (First, Middle, Last)	street and number) ing Home 7. Age 7. Age 7. Age 12. Was Decedent Ev Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		EI If Under Months ocation POSIT	ktor 1 Year Days Code	If Under 24 Hours N		6, 2 40 Birth Day, Year 17,	004 c. County of Ceci 1930	9. Birthpl Coun NOYL	h Caro	r Foreig
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20a. Method of Di	sposition ⊣ДCremation 3 ⊟F	Removal from State	20b. Place of Dispo cemetery, crei	matory or ot	her place		Date	20c. L	ocation - C	ity or Tov	wn, State	
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3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, str (Specify)	-		20.00	28f. Location City or To	(Street an	nd Number a)	or Rural	Route Numb	er,
	1 Certifying Phy 2 Medicel Exami	ner: On the basis of ex	kamination and/or in	h occurred a	t the time	, date and pla	ce, and due to the	e cause(s)	and mann	ner as sta	ted.	
		and manner state	d.									
29b. Signature and	title of certifier	\sim			0-1	005	6	-500	1-1			
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Sequentially last conditions contributing to death but not resulting in the underlying cause given in Part I.	1317 Cokesbury Road, Abingdon, Ma 23a Petri. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. It is only one cause on each line. It is only one cause on each line. It is only one cause on each line. It is only one cause on each line. 23a If FEMALE: 236. If yes, outcome of pregnancy 1 Live birth 2 Fertal death 5 Other (specify) 9 Unknown 9 Unknown 1 Yes 2 No 3 Probations 1 Yes 2 No 3 Probations 1 Yes 2 No 3 Probations 2 2 2 No 3 Probations 2 2 2 No 3 Probations 2 3 2 2 No 3 Probations 3 2 2 2 No 3 Probations 3 2 2 2 2 No 3 Probations 3 2 2 2 No 3 Probations 3 2 2 2 2 2 2 2 2 2	Sequentials list conditions Sequentials list list list list list list list li	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 13, 2004 7:30PM May Van Buren Brooks /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner Prince Georges 400 Jean Wood Court If Linder 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) Funeral Days Months Hours 1**X** M 2□ F Yrs 76 Director May 6, 1928 Virginia 230-20-0864 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director Prince Georges MD Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 20721 USA 400 Jean Wood Court Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 1 Yes 2 □ No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: If Yes, Give Year or Dates: Unknown þ **Black** 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) US Government Mail US Postal Employee 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Van Buren Brooks, Sr. Alice Byrd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gina Screen- Daughter 400 Jean Wood Court, Bowie, MD20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverview Cemetery 5/20/04 Charlottesville, VA 22 Name and Address of Facility 21. Signature of Funeral Service Licensee McClenny Funeral Service 22903 600 Henry Ave., Charlottesville, VA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical 1Hour Cardio Pulmunary Arrest Examiner Due to (or as a consequence of) Examiner Diabetes Mellitus ed by the attending physician end detached for use as the burial-transit The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Due to (or as a consequence of). 23b. Did tobecco use contribute to the ceuse of deeth? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3X Probably 4 ☐ Unknown Hypertension, Emphysema δ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed performed? 1 ☐ Yes 2 🛣 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Piece of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To

Box 68760 Division of Vital Records, P.O. To the Hospital or Attending Physicien: The law requires the within 24 Hours after death.
To the Funeral Director: After this certificate has been signs completely filled in by the funeral director, page 2 should be

edicai

State Registrar

JA QUINS MO

29c. License number D29256

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

🛣 Certifying Physiclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at Work?

1 Yes 2 No

Bethesda, MD

29d. Date signed (Month, Day, Year)

May 14, 2004

Location (Street end Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

20814

30. Name and appress of person who completed cause of death (Item 23a) (Type, Print)

4343 Montgomery Ave, Jose//A. Quiros MD

Date of Injury (Month, Day Year)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

27. Manner of Death

1 X Natural

2 Accident

3 Suicide 4 Homicide

29a. Certifier

<u>JUN 1 1</u> 2004

5 Pending investigation

6 ☐ Could not be determined



28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- Stata Registrar AMEND ITEM #1 PER PHY G832 6 Pett/fite at #1 Death 2. Date of Death 3. Time of Death LARRY D. BOYSSEAU Month **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Burnie North Arundel Hospital Arundel Glen Anne If Under 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Davs Hours Min. **1**€ MM 2 □ F 46 Yrs. Director 228-88-7039 Ω6 14 VΔ Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 'natural', or Itams 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 🏋 🗓 No Director Glen Burnie Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 21060 U.S.A. Funeral 223 Warfield Road death 12. Was Decedent Ever in U.S. Armed Forces? 1 Ø Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status e filed within 72 hours after dail Hygiene.

othar than "natural", or Itam Black, White, etc. 1 Never Married XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: \$ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) U.S. Government Elementary/Secondary (0-12) College (1-4or 5+) Printing Office permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If Itam 21 is marked other than any injury or other traumerto Print Shop Specialist 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Jane Jackson James Boisseau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 223 Warfield Road, Glen Burnie, Md 21061 Sarah A. Boisseau-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) 6/11/04 Crownsville, Md Crownsville Vet. of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore Md 21215 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequent Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit certificate be executed Due to (or as a consequence of): attending physician Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par 2 2 No 3 Probably 4 Unknown 1 Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an this certificate has autopsy 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 036256 ress of person who completed cause of death (Item 23a) (Type, Print) and a

State Registrar

DHMH 17 Rev 1/2001

JUN 1 1 2004.

31. Date filed (Month, Day, Year)

Jorge Ramirez,

ORIGINAL

Hospital Drive, Glen Burnie, Maryland 21061

301

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra MEND ITEM #19b PER FH G832 Certificate of Death Reg. No... 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 20ď4° 0 5 -. /Medical 4b City, Town, or Location of Death 4c. County of Death Fecility Name (If not institution, give street and number) Examiner Balhmore COURT MM21224 BU15014 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 9. Birthplace (State or Foreign 0916 **Funeral** Days Hours 1 XM 2 ☐ F 82 Director NC Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County il Hygiene. other than "natural", or items 23e or 28e-f show vent, the Medical Examinar must be nutified at POALIMO DE CTIY BALTIMOVZE Yes 2 No M Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? JULFURY 2122 USA 4100 C0 permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If tem 27 is marked other them... 12, Was Decedent Ever in U.S. Armed Forces? 1 Byes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Beth you stee WORKE Bethlehem Steel Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Isaiah Parker Mary Cotton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7100 Beauford Ct. Apt 203, Baltimore, Md Louvenia Cotton-Wife 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State WXBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Nationl Park 6/11/04 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H West wabash Avenue Balto, Md 21215 23a-2an1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumonia Physician /Medical Due to (or as a consequence of): heart failure-wolsened Examiner Sequential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a cons Division of Vital Records, P.O. Box 68760. Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month in the past 12 months? Year Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Canco 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Sidence 6 Other (Specify) 2 1 Yes 2 ER/Outpatient 3 DOA 2 After this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; Hospital or Attending Natural 5 Pending investigation To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A N 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place ol Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier BRUNN ANGELA GALTO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KNPFF 419 WEST REDWOOD STURE BROWN MD 2120

DHMH 17 Rev 1/2001

State Registrar 31. Date liled (Month, Day, Year)

JUN 1 1 2004

32. Registrar's Signature

Elaine W. Demme Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04 - 3797State of Maryland / Department of Health and Mental Hygiene, For State Registra AKG 1-Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Elaine Wallach June 7, 2004 2:37 P^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Abingdon
If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
Jan. 5, 1954 3423 Clairborne Way Harford Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1□M 2☑F Months 50 Director New York 143-46-8087 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental hygiene.

ent: If item 27 Is marked other than "naturel", or Items 23a or 28e-f show ury or other traumatic event, the Medical Examiner must be restilited at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 1 ☐ Yes 2 No Maryland Directo Harford Abingdon 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3423 Clairborne Way 21009 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ZNo Specify: Specify White Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Regional Manager Liquor Manufacturing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Samson Jacob Wallach Lillian (NMN) Glazer 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) David W. Demme - Husband 3423 Clairborne Way, Abingdon, Md. 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. Hilltop Corporation 6/10/04 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Cloep See McComas Funeral Home 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Intraval Gustor wound **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Ö detached 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 2□ No certificate 2 No Yes Yes Physicien: filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence At scene 2 1XXYes 2 No this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 27. Manner of Death 28c. Injury at Work? : After t Attending Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 X No 1104 MICHIN SURTECT SHOT death. SEIT 2 Accident 6 Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3423 Clarbulle willy 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 0 To the Hospitel o within 24 hours aft To the Funerel Di residence Asingdon MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig O.C.M.E. June 8, 2004

State Registrar 30. Name and address of persor

31. Date filed (Month, Day, Year)

JACU

111 Penn Street, Baltimore, Maryland 21201

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D

		1	For State Registrar	State of Maryla	nd / Depa <i>Cer</i>	irtment of H tificate of I	lealth and M Death	lental Hyg	iene _{eg. No.} 2 (104	18369
	Dhysiair	_	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia /Medic	al .	Streta Davis					06	07	04	0 600AM
	Examin	CI I	4a. Fecility Name (If not institution, give s				r Location of Death		4c. Count		
			Mercy Medical Co	enter 7 Age (10 vo	s. last birthday)	Baltim If Under 1 Year	ore If Under 24 Hrs.	8. Date of Birth	NA		lace (State or Foreign
ш	Funeral Director			M 2□ F 69	Yrs.	Months Days	Hours Min.	(Month, Day 1–10–3	Year)	S.C	lace (State or Foreign try)
			Usual Residence of Decedent	1 05				1-10-			•
	yland		10a. State 10b. County	10c. 0	City, Town or Lo	cation				1	0d. Inside City Limits
	a-f s	cto	Md NA		Baltin	nore					1√ Yes 2 No
	or 28	Olre	10e. Street and Number			10f. Zip Code		1	og. Citizen of		ntry?
	ath w	by Funeral Director	315 Forrest St			21202		naifu Van as Na		ce - Americ	ean Indian
	ter de	nue	11. Marital Status 1 ☐ Never Married 2 ☒ Married	 Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No 	0.5.	f Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)		ick, White,	
36	rs aft	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2XNo	Specify:		Speci	∳∵ Bla	ck
Ş	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Madical Exertified round be motified at	ed	15. Decedent's Educ	eation	16a. Deced	ient's Usual Occup	ation		16b. Kind of E	Business/Ind	dustry
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п	al Hy d oth	Be (17. Father's Name (First, Middle, Last)	_			18. Mother's Name Blanch	e (First, Middle,	_	me) argan	
yla	Mend Mend Mend Mend Mend Mend Mend Mend	ပ္	Jule		vis			-10- 4- No1-			Contal
Maryland 21215-0036	2 sh and is m		19a. Informant's Name/Relationship (Type Sallie Mae Davis	oe, Print) Wife		Forrest	and Number or Rura	Baltimo			
e,	1 and Health am 27 ther t		20a. Method of Disposition		And the second second	sition (Name of natory or other place		Date	20c. Location	- City or To	own, State
Ö	ages nt of l		1 Burial 2 □ Cremation 3 □ R			natory or other plac of Faith	6-11 -	06	Baltin	nore	, Md.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic avant, the Madical Examination and page.		4 ②Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	10.11	22	. Name and Addre	ss of Facility	Balt	imore,		21202
_	40 E # 9		Deadis	Wane		March F.F			E. Nort	en Ave	Approximate
H			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the de le cause on each line.				or respiratory arr	85 1,		Interval Between Onset and Death
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В	/Medical Examiner		1	Due to (or as a cons	equence of):						
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8760,	cate be executed physician and the burial-transit	dical	d	l							
θ	ng ph	Med	IF FEMALE:								
Вох	eath certifii attending p for use as	an/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fo	etal death 3	Ectopic pregnanc	у		1	ate of delive	ery Day Year
	e dea the al	Physician/Me	1 Yes 2 No	4 ☐ Pregnant at time o 9 ☐ Unknown	f death 5	Other (specify) _					
P.0	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as		Part II. Other significant conditions con	ntributing to death but not r	esulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use cor	ntribute to th	he cause of death?
Vital Records,	signe d be	d by				, ,		1 🗆 Y	es 2 No	3 Prob	pably 4 Onknown
Ö	w require been si	ete						24a. Was a	an 24b	Were auto	psy findings available
Rec	The law cate has I	Completed						autop	med?	prior to condeath?	impletion of cause of
a			25. Was case referred to medical				26. Place of Deat		2 [MO	1 🗆 Yes	2 No
⋚	Physician: this certific ral director,	o Be	examiner?	lospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA Ott	200	me 5 Resid		her (Specif	(v)
of			27. Manner of Death	28a. Date of Injury (Month, Day Year,	28b. Time o	-		28d. Describe h			,,
io	Attending For death. ector: After by the funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(MOTH), Day 16al	, injury	M 1	Yes 2 □ No				
Division	or Attendate death Director: In by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, st	reet, factory, office		28f. Location (S City or Tow	treet and Num n, State)	ber or Rura	al Route Number,
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	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Exami	sician: To the best of my liner: On the basis of exam	knowledge, deat ination and/or in	n occurred at the ti vestigation, in my	me, date and place, opinion, death occur	and due to the or red at the time, or	ause(s) and n date and place	nanner as s , and due to	stated. the cause(s)
	thin 2 the the implel	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date sign	ed (Month,	Day, Year)
	¥ ¥ ¥ 8		0 1	dinan .	AD	PII	400		06 - 0	7-0	4
•	4		30. Name and address of person who co	ompleted cause of death //	tem 23a) (Tyne	Print)	100				•
)	Darne Friedm	an 301	saint	Paul Pl	ace Ba	Himore	Man	ylan	d 21202
14	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig							
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ORIGINAL

		-	For State Registrar	State of	Marylan	•	artment of I rtificate of		1	Re	g. No.) 4	18370
-	Physici	an	Decedent's Name (First, Middle DAMD TOTA		1 4 62 13 7 7 7 7	200			M	ate of Death onth	Day	Year	3. Time of Death
	/Medic	al	PATRICIA		HAZELW	עסט	4b. City, Town, o	or Location		JNE 2,	2004 4c. County	of Death	6:30 PM
	Examin	er	4a. Fecility Name (If not institution, 1206 SIMMONS	-) Jeir)		ROCKV		or Deali		MONTG		7
	Funeral		5. Social Security Number		Age (In yrs.	last birthday)	If Under 1 Year	If Under	24 Hrs. 8. Da	ate of Birth		9. Birtho	lace (State or Foreign
	Director		232-62-2380	1□M 2፟∭F	65	Yrs.	Months Days	Hours	Min. MAR	fon <i>th, Day,</i> CH 5,	1939	MAR	YLAND
	۵ ,		Usual Residence of Decedent		10a Cit	y. Town or Lo	anting					1	0d. Inside City Limits
	ehov	=	10a. State 10b. County			,,	cation					,	1 □ Yes 2 □ No
	the M	Director	MARYLAND MONTG	OMERY	ROC	KVILLE	10f. Zip Code			10	g. Citizen of W	/hat Cour	ntry?
	deeth with the Marylen ems 23a or 28a-f ehow er riukt be notified at	급	1206 SIMMONS DR	TVE			208	51			U.S.A.		,
	deeth	Funeral	11. Marital Status	12. Was Deced	ent Ever in U	.S. 13.	Was Decedent of I		igin? (Specify Y	es or No-	14. Race	- Americ	an Indian,
9	or ite		1 Never Married 2 Marri	ied 1 Tyes 2	X No		n Yes, specnry Cub 1 ☐ Yes 2X No			, etc.)	Specify	k, White,	etc.
8	72 hours after deeth with the Marylend "natural", or Items 23a or 28a-f ehow idical Examiner must be notified at	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dat	es:							MHT	
5		Completed	15. Decedent (Specify only highes	's Education st grade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	petion during mos	st of working	1	6b. Kind of Bu	siness/In	dustry
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Maryland 21215-0036	d 2 should thend Men 7 is marke treumatic		19a. Informant's Name/Relations	hip (Type, Print)			ng Address (Street				•	State, Zip	Code)
	8 -		EDWARD P. POE				ANOR DR.	, HAG	-	-			
ore	8 6 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 ☐Removal from SI		Place of Dispo cemetery, crea	sition (Name of matory or other pla		Date		0c. Location -		own, State
Ē	tant:		'4 □Donation 5 □ Other (S		MAP		CEMETER		UNE 7, 2	2004	ELKINS	, WV	
Baltimore,	permit. Page Department Important: If eny injury or		21. Signature of Funeral Service	Petth.	ucon	I	Name and Address OMBLYN F	UNERA	Ĺ HOME	WV 20	6241		
Vital Records, P.O. Box 68760,	iclan: The law requires that the deeth certificate be executed Exponential to the second property of the stending physician and property rector, page 2 should be detected for use as the burlal-transit	3e Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (o c. Due to (o d. 23c. If yes, outco 1 Live bir 4 Pregna 9 Unknow	r as a consect r as a consect r as a consect one of pregnith 2 Fete nt at time of consect one	uence of): uence of): uence of): ancy death 3 [leath 5 [Ectopic pregnanc	ven in Part	2	1 Yes	Mor acco use contr s 2 \(\overline{\text{N}} \) No 24b. V ed? \(\overline{\text{N}} \) No	e of deliventh	Day Year ne cause of death? ably 4 Unknown psy findings available mpletion of cause of
<u> </u>	d is	To B	examiner? 1 ☐ Yes 2 ☒ No	Hospital:	patient 2	ER/Outpatie	nt 3 DOA Ot	her: 4 🗆 N.	ursing Home	5X Resider	nce 6 Othe	er (Specif	v)
on of	Jing After fune		27. Manner of Death 1 X Natural 5 Pendin 2 Accident investig	y .	Injury , Day Year)	28b. Time o Injury	Wo	ryat ork?]Yes 2. □		Describe how	w injury occurr	ed	
Division		Certification:	3 Suicide 6 Could 4 Homicide determ	inord 288. Place C	of Injury - At h g, etc. <i>(Speci</i>		reet, factory, office			ocation (Stre lity or Town,		er or Rura	l Route Number,
	To the Hospital or within 24 hours effet To the Funeral Dir completely filled in	Medical C	29a. Certifier 1 X Certifyin (Check only one) 2 Medical	ng Physician: To the b Examiner: On the bas and manne	sis of examina	owledge, deat ation and/or in	h occurred at the to vestigation, in my	ime, date a opinion, de	nd place, and du ath occurred at	ue to the car the time, da	use(s) and ma te and place, a	nner as st and due to	ated. o the cause(s)
	To the within To the comp	Ň	29b. Signature and title of certifie		-0		29c. Licen	se number		29	d. Date signed	(Month,	Dey, Year)
	-		Thing		204		D430	083		J	UNE 3,	2004	}
	1		30. Name and address of person GEORGE A. SOTO				Print) CENTER I	DR., F	ROCKVILI	LE, MD	20850		
2	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUN 1 1 2		gistrar's Sign		w						

		ľ	1 - For State Registrer	State of	Marylan	d / Depa <i>Cer</i>	irtment of tificate of	Health and Death		iene 200	4 18371
H	Physici	an	Decedent's Name (First, Middle, Canada la						2. Date of Deat Month	Day Yea	
	/Medic	cal	James Gartle		oer)		4b. City. Town.	or Location of Deal	TUNE	4c. County of D	0043:15 PM
	Examin	ier	Upper Ches			enter	Bel Ai			Harf	
	Funeral Director		5. Social Security Number 220–14–5031	6. Sex 7 1 ☐ M 2 ☐ F	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Yea Months Days			⁷ 1924 M	Birthplace (State or Foreign Country) aryland
pos	*		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
Mak	-f sho	tor	Pennsylvania N	ork.	Pe	each Bo	ottom				1 □ Yes 2≹ No
t et	or 288	Oirec	10e. Street and Number				10f. Zip Code		10	0g. Citizen of What	
t diag	s 23a	Funeral Directo	1244 Tanning N	ard Hollo		C 12 V	1756		Specify Ven or No.	US	A merican Indian.
U Z I Z I 3-0030	The fair and Mental Hygiene. Health and Mental Hygiene. Other treumatic event, the Medical Exameter must be inclined at	by Fune	11. Marital Status 1 □ Never Married 2 Marrie 3 □ Widowed 4 □ Divorced	Armed Force	es? No	"	Yes, specify Cu	Hispanic Origin? (Span, Mexican, Puer Specify:	to Rican, etc.)	Black, W	
5 8	natura	eted	15. Decedent' (Specify only highest			(Give	ent's Usual Occu	during most of wo	rkina	16b. Kind of Busine Harford	ss/Industry
with A	than the Man	Completed	Elementary/Secondary (0-12)	College (1-4	lor 5+)	life. D	OO NOT use retir	ed)			Education
T Tag	matic evant, tro m	e e	17. Father's Name (First, Middle, L	ast)		Carpe	encer	18. Mother's Na	m <i>e (First, Middle, N</i>	Maiden Surname)	
should be	Menta Menta arked atic ev	To B	Gaither Winfi	eld Jone:	s			Ina Ma	ry Rhodes	5	
- 0	Ith and Ith and Ithen It		19a. Informant's Name/Relationsh Martha Jones /	· · · · · · · · · · · · · · · · · · ·		1				City or Town, State	
,	Healt tem 2 other	1 2	20a. Method of Disposition	 	20b. PI		TallILLIG sition (Name of natory or other pl			20c. Location - City	, PA 17563 or Town, State
	nent of int: If i	١.	1 Burjal 2 □ Cremation 1 4 □ Donation 5 □ Other (So		ate			. Cem. 6-	-10-04 T	Forest Hi	LL, MD 21050
Dallillo	penini. Tages land importent: If item 2 any injury or other once.		21. Signature of Papers Service	censee (t	_		Name and Addi			OLOGO III.	
×	*		23a. Part1. Enter the disease, or of the chock, or heart failure. List of	complications that cau	used the death	. Do not ente	er the mode of dy	ing, such as cardia	c or respiratory arre	est,	Approximate Interval Between
	nysician		Immediate Cause (Final disease or condition resulting in death)				207100				Onset and Death 12 H25
	/Medical xaminer		resulting in death)	Due to (or	as a consequ	ience of):	-1				17,400
	3,100	Jer	Sequentially list conditions, if any leading to immediate	b. Due to o	r as a consequ	ence of					12 11063
political	and transil	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o. Ilv			906710	- ANEI	x/500		
cate he avecuted	sician a	al E	rosuning in south) cast	Due to (or	r as a consequ	ience or):					
OO /	g phys	ledical		d.					_		
UIVISIOII OI VIIGII DECOIDS, F.O. BOX OF Health and Controlles that the death call	requires man me deam deministrate of account been signed by the attending physician and should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ∏ Fetal ntattime of de	death 3	Ectopic pregnand Other (specify)	ey .		23d. Date of o	delivery Day Year
J. T.	gned by	by Ph	Part II. Other significant condition	ns contributing to dea	th but not resu	ilting in the un	derlying cause g	ven in Part I.	23e. Did tob	acco use contribute	to the cause of death?
COLCS,	been si	eted	A34 hma				_		1 □ Ye	s 2□No 3□	Probably 4 Munknown
	cete has b	Completed							24a. Was ar autopsy perform 1 \square Yes 2	led? death	autopsy findings available o completion of cause of?
VICAL	certifi	o Be	25. Was case referred to medical examiner? 1 \sum Yes 2 \text{No}	Hospital: 1 ☐ Inc	national 2 M	ER/Outpatient	25 200	han	ath (Check only one	/	
ing Phy	After this funeral d	l⊫⊹,	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Month,		28b. Time of Injury	28c. Inju		28d. Describe ho	nce 6 □Other (Sp w injury occurred	овсту)
DIVISION I	within 24 hours after death. To the Tunerell Director: After this certificate has I completely filled in by the funeral director, page 2.5	Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determin	ot be 28e. Place o	f Injury - At ho g, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (Str City or Town	eet and Number or , State)	Rural Route Number,
Hoenite	24 hours Funere letely fille	edical C	29a. Certifier Certifying (Check only one)	Physician: To the b xaminer: On the bas and manne	is of examinat	wledge, death ion and/or inv	occurred at the estigation, in my	ime, date and place opinion, death occ	a, and due to the ca urred at the time, da	use(s) and manner ate and place, and d	as stated. ue to the cause(s)
T C	withir To th comp	Me	29b. Signature and title of certifier	. 11.				se number		d. Date signed (Mo	
			1/ hujme	Mum	w w	10	104	1749	3	TUNE 8	12004
	10		30. Name and address of person v	no completed cause	of death (Item	23a) (Type, F UPPC (Print) Che SADE	ake or	1 V/2 Belt	TUNZ 8	21014
	Sta Registr		JUN 1 1 2004	32. no	gistrar's Signat	4	books				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year LEMARR FREDDY MALCOLM June 2009 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Buttinge State of Birth (Month, Day, Year)

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

March 5, 19 HOSPI to Johns HO 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 1XM 2□ F 415-70-5031 61 1943 Tennessee Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No Strawberry Plains Tennessee Knox 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8655 Shakleford Lane 37871 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status n XXYes 2 □ No
If Yes, Give
Year or Dates:Vietnam 1 Never Married 2 Married 1 ☐ Yes 2XX No Specify: Specify: white 3 Widowed 4 N Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed)

marketing division accounts exec.

18. Mother's Name (First, Middle, Maiden Sumame)

within 72 hours after death with the Maryland Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28e-1 show ary or other traumatic avent. The Medical Expr. it act must be collided at permit. Pages 1 and Department of Health Important: If Itam 27 any injury or other tr

Baltimore, Maryland 21215-0036

Box 68760,

P.O. |

Division of Vital Records,

Physician

/Medical

Examiner

10a. State

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Director

Completed by Funeral

Be

2

Funeral

Director

Physician /Medical Examiner

> Examiner death certificate be executed -tran and attending physician a for use as the burial Physician/Medical the detached signed by t by Completed page 2 should peen has certificate ! Physician: funeral director After this Certification: or Attending

Louise Muriel Emeret Malcolm Eugene LeMarr 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 23205 Cornerstone Dr. Yardley, PA 19067 Dana Louise LeMarr/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Asbury Cemetery June 11,2004 Knoxville, Tennessee 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell Wiedefeld Funeral Home, 21. Signature of Funeral Service Licensee . Mitchel Baltimore, MD 6500 York Rd. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrest, skipck, or heart failure. List only one cause on each fine. Immediate Cause (Final SEPSIS disease or condition resulting in death) Due to (or as a consequence of): EUKEMI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospitaf: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🔼 Cartifying Physician: To the best of my knowledge, death occurrad at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and placa, and due to the causa(s) and manner stated. (Check only

College (1-4or 5+)

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu the Hospitel

> State Registrar

KENNETH BILCHICK 31. Date filed (Month, Day, Year)
JUN 1 1 2004

Kenneth Belchick, MD

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 NORTH WOLFE STREET 32. Registrar's Signatore

ORIGINAL

29c. License number

RES-000

Phone company

Month

29d. Date signed (Month, Day, Year)

JUNE 7, 2004

Approximate Interval Between Onset and Death

2 WEEKS

MONTHS

Year

Day

CARNEGIE 568 BALTIMORE, MARYLAND 21287

		_	For State Registrar	State	of Maryla	and / Depa <i>Cea</i>	artment of F	lealth a Death	nd Mer		iene 20	04	18373
ı	Physici		Decedent's Name (First, Middle	william	R. L	yons				Date of Deat Month June		Year	3. Time of Death
e.	/Medic Examin		4a. Facility Name (If not institution Chesapeake H				4b. City, Town, o	r Location of	f Death		4c. County Anne	of Death	
	Funeral Director		5. Social Security Number 222-20-6942	6. Sex 1 (\$\frac{1}{2}\$\text{M} 2 \subseteq F	7. Age (In y	rs. last birthday) 66 Yrs.	If Under 1 Year Months Days		Min. 8.	Date of Birth (Month, Day, une17	Year) , 1937	9. Birth: Coul Del	place (State or Foreign ntry) aware
	faryland show	ō	Usual Residence of Decedent 10a. State 10b. County MD Balt	imore	10c.	City, Town or Lo	White M	March		-		1	10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	with the A a or 28a-	Director	10e. Street and Number 5513 Madge				10f. Zip Code	2116			0g. Citizen of V	Vhat Cou	ntry?
2	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health ard Mental Hygiene. It is marked other than "naturel", or Items 23e or 28e-f show other traumatic svent, if a Medical Exarchar must be rediffed at	by Funeral	11. Marital Status 1 □ Never Maπied 2 Mar 3 □ Widowed 4 □ Divorced	12. Was De	2 No	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 XNo				14. Race Blac	- Americk, White,	
20-61313	within 72 hou lene. then "neture ite Medice E	Completed		nt's Education est grade completed		(Give	dent's Usual Occup kind of work done DO NOT use retired ract Au	during most			16b. Kind of Bu		dustry Defense
אומוות ע	should be filed nd Mental Hygi marked other umatic svent, I	To Be Co	17. Father's Name (First, Middle, Vernon Lee	Lyons				Hel	en Ma	ae Wi			
Ž.	s 1 and 2 sh f Health and item 27 Is rr other traurr		19a. Informant's Name/Relations Dianna Lyons 20a. Method of Disposition	s /wife		551	ng Address (Street 3 Madge sition (Name of matory or other place	Cour		ite Ma		D 2	116
altillo	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.	1	1 ⊠ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral Service	Specify)	State G	Sarrisc	on Fores Name and Addre	t e	6/11/ Conn		Baltin		e MD neofEssex
			23a. Part1. Enter the disease, o shock, or heart failure. List	r tions that t only on cause on	caused the de	eath Dirt en			Ave.	Balti	more 1		
	Physician /Medical Examiner		disease or condition resulting in death) Sequential list conditions.	b	(or as a cons		elly	38h	mh				1 /5
	ate be executed hysician and the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a cons								
.O. DO.	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	hysiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of preports of preports of the preports	etal death 3	Ectopic pregnancy Other (specify)	,			23d. Date Mor		ery Day Year
ר (צמוס	equires that en signed b ould be deta	by P	Part II. Other significant conditi	ons contributing to	death but not	resulting in the u	nderlying cause giv	en in Part I.			_		he cause of death? pably 4 🕬 nknown
	: The law re cate has be page 2 sho	Completed								24a. Was ar autops perform 1 Yes 2	y p ned? d	Vere auto rior to co eath?	opsy findings available impletion of cause of
VISION OF VIEW	To the Hospital or Attending Physician: The law within 24 buous after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation: To Be		Hospital: 1 [28a. Date (Mo	Inpatient 2 of Injury onth, Day Year	EP/Outpatier 28b. Time o	f 28c. Injur Wor	er: 4 🗆 Nur:	sing Home 28d.	heck only one 5 ☐ Reside Describe ho			peaks House
	ital or Atte	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 200. Plac	ce of Injury - A ding, etc. (Spe	t home, farm, st ecity)	reet, factory, office		28f.	Location (Str City or Town	reet and Numbe , State)	er or Rum	al Route Number,
	the Hosp thin 24 hou the Fune mpletely fil	Medical	29a. Certifier (Check only one) 2 Medical 29b. Signature and little of certifier		ne best of my libasis of examiner stated.	knowledge, deat ination and/or in	h occurred at the tir vestigation, in my o	pinion, death	f place, and h occurred a	it the time, da	ate and place, a	nd due to	the cause(s)
	. T		Jonnes	161 L	2	20017	6	31	337	25	June Burn	9, (U094
	∫ U Sta	ate	30. Name and address of person Si Date filed (Month, Day, Year	Deleur	Registrar's Sig	20	Tot its	DI	ve,	GAn	Burnit	14	. 2106/
(1)	Regist		JUN 1 1 20	E.	a st	Court	e e						

State of Maryland / Department of Health and Mental Hygiene 200118376 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death JUNE 7, **Physician** Year 2004 LAUFER 7:50 P ERNEST /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9122 RUTH ELDER LANE PIKESVILLE BALTIMORE 8. Date of Birth Month, Day, Year) NOV. 19, 1927 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) GERMANY 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 1**X** M 2□ F Hours 76 Yrs. 073-22-8554 Director Usual Residence of Decedent 10a State 10b. Count 10c. City. Town or Location 10d. Inside City Limits or 28a-f show other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🙀 No Director BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 "naturel", or Items 23e 9122 RUTH ELDER LANE U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 □ No ARM If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or item any injury or other treumatic event, the Medical Examinat once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE þ 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICAL ENGINEER ENGINEERING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LAUFER MARGARET FREUNDLICH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MINDY LAUFER / WIFE 9122 RUTH ELDER LANE - PIKESVILLE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MIKRO KODESH BETH ISRAEL 6/9/04 ^ 4 □ Donation 5 □ Other (Specify) BALTIMORE, MD e of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 One 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final leuKemia Pnysician 2 weeks disease or condition resulting in death) /Medical lymphocytic leukemia Examiner chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner poly cythemia years burial-transit certificate be executed Due to (or as a consequence of) attending physicien Box 68760 ian/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) Physici P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. portal Vein 2 12 No 3 Probably 4 Unknown Completed diabetes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed (es 2 No 1 ☐ Yes 2 🗌 No Division of Vital To the Hospitet or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 [[Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) Monument St., Rm 8068 Bultimore MD 21287 32. Registrar's Signa 31. Date filed (Month, Day, Year) State JUN 1 1 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registreramend item 35 PER FH G832 6/@e/tipicate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** NORMAN W. NEVILLE 6:14 AM JUNE 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE HOSPITAL n/a HARBOR CENTER If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 □ M 2 □ F 214-30-6715 69 Sept.22 1934 Washington D.C. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 is marked other then "neturel", or items 23a or 28a-f show treumstic event, the Medical Exeminer must be modified at 1 ☐ Yes 2 No Md. Harford County Aberdeen Director 10g. Citizen of What Country? 10e.Street and Number 1311 S. Philadelphia Blvd. # 5 10f. Zip Code 21001 U.S.A. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. fited within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white ⋧ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. marked other then Elementary/Secondary (0-12) College (1-4or 5+) Painter Construction 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mahaloc R. Neville Sr. Anna Rose Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3043 Freeway, Baltimore, Md. 21227 (Daughter) Norma Jean Neville f Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State urtment ortant: I injury Cedar Hill Cemetery | 06/11/2004 Baltimore, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuheral Service Licens. 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A. any ii M00922 237 E. Patapsco Ave. Baltimore, Md. 21225 23a. Part in er the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. mmediate Cause (Fin II HEART FABIUR CONGESTINE Physician 4eurs /Medical Due to (or as a consequence of) Examiner BLEEDENVO CLASTRUINTESTINAL Sequentially list conditions, if any, leading to immediate the sequence of the Due to (or as a consequence of): Examine attending physician and for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ LEG ULCER 1 Yes 2 No 3 Probably 4 Unknown HEALING HYPERTENSION MELLITUS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Comple DIABETES 24a. Was an autopsy performed certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Box 68760 Division of Vital Records, Director: After this certific J in by the funeral director. within 24 hours after death. To the Funerel Director: A filled

> State Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year) JUN 1 1 2004

4 Homicide

(Check only one)

29b. Signature and title of certifier

Hirw

29a. Certifier

32. Registrar's Signature

3001

and manner stated.

Cebrewold

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEBREWOLD

SOUTH

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES OOI

HANDVER

29d. Date signed (Month, Day, Year)

JUNE 7 2004

STREET, BALTIMORE, MD 21225

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 Month June 7, **Physician** 9:20 p Ritchie Mary Lou /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Laurel 9010 Briarcroft Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** Days Hours 1 M 2 X Yrs April 8 1936 Washington, 68 577-48-4117 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10b. County 10a State 23a or 28e-f show ust be notified at 1☐Yes 2√X Laurel Director MD Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20708 U.S.A. 9010 Briarcroft Lane #407 Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 6 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify White ð 3XXWidowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than "natur 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Grade 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental I Dorothy M. Le Grey Arthur F. Kelly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health it 354 Chaptico S. Laurel, Maryland 20724 Dorothy Hunter / sister Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of F
Important: if Ite
any injury or ot 1 ☐ Burial 2 【XXemation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 6/9/2004 Odenton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home, P.A. Grz 8 Laurel, Maryland 20707 / M00770 313 Talbott Avenue 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List pnly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) since 11/02 Non-small cell carcinoma of lung Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate and Enter Under in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🖾 💥 o 4☐ Pregnant at time of death 5 Other (specify) been signed by the a should be detached Records, P.O. 9 Unknown 9 Unknown hed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by XXYes 2 □ No 3 Probably 4 Unknown Chronic obstructive pulmonary disease 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ Xo Seizure disorder page 2 s 2XXio 1 🗌 Yes Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home SXXResidence 6 Other (Specify) Certification: To 1 ☐ Yes 2XXVo this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 XX atural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident hours after deat 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 THomicide within 24 hours aft To the Funeral DI completely filled in the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D 21294 June 8, 2004 30. Name and address of person who comsuse of death (Item 23a) (Type, Print) 3450 Fort Meade Road Laurel, Maryland 20724 Abdul Nayeem, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar 2004

			For State Registrar			Maryland		artment rtificate			and M		Reg. No.	200) 4	18	<u>377</u>
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	Exami	ner	4a. Facility Name (If			nber)				Location of				County of			
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Maryland 21215-0036	s within 72 hours after death with the Maryland liene. r then "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at	by Funeral	11. Marital Status	ed 2 Marned	1	dent Ever in U.S ces? 2 ☑ No	- 1	Was Decede If Yes, speci			gin? (Spe n, Puerto I	cify Yes or No Rican, etc.)		14. Race Black,	White,	_	
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Baltimore,	permit. Pages 1.and Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disp 1 DBurial 2 C 4 Donation	Cremation 3	Removal from S	Ce	ace of Dispo metery, crei rt LIr	natory or ot	e of ner place		-12 - (ate)4		cation - C ntwo			
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	Hosp 24 hou Fune stely fil	edical	29a. Certifier (Check only one) §	1 XCertifying F 2 Medical Exa	Physician: To the aminer: On the ba and mann	sis of examinati	vledge, deatl on and/or in	n occurred a vestigation,	t the tim in my op	e, date an inion, dea	d place, a th occurre	ind due to the ed at the time,	cause(s) date and	and mann place, and	ner as st d due to	ated. the cause	(s)
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	Ci		30. Name and addre	ess of person who	o completed cause	of death (Item	23a) (Type,	Print)		1000	n.: 1	0		MD 1	2000	2	
					upta, MD			Aven	ue #	220	SILVE	er Spri	ng,	MD - 2	2090		
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State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Nancy Lee Rimbey 2004 June 8, 0445 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Mary Land 8. Date of Birth (Month, Day, Yeer) Dec 9,1943 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2√□ F Yrs. 215-42-6202 60 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Westminster 1 ☐ Yes 2√ No Director Maryland Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21157 1011 Hemlock Lane USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: white 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Mesone. Elementary/Secondary (0-12) College (1-4or 5+) Clothing Presser 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph T. Ross, Sr. Loretta Ann Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willard E. Rimbey, Jr, Husband 1011 Hemlock Lane, Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition ty Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 06/11/2004 Finksburg, MD Pleasant Grove Cem. 21. Signature of veral Service Licensee 22. Name and Address of Facility Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit Due to (or as a consequence of): Vital Records, P.O. Box 68760 Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for Day in the past 42 months? 1 □ Yes 2 □ No Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð pe 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed CARDIO MY OPATHY. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed res 2 certificate 2□ No the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 1 🗌 Yes 2 ER/Outpatient 3 DOA Division of Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After To the Hospital or Attending Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and little of certified mura 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M) 224 31. Date filed (Month, Day, Year) '32. Registrar's Signature State Registrar

		1 - For State Registrar	State of Ma		l / Depa		t of H	ealth a		R	iene	200	4 18379
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/Medi Exami		4a. Facility Name (If not institution, give Saint Joseph	street and number)					Location o	of Death		_	County of D	
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permit. Pages Department of Importent: If i eny injury or o		21. Signature of Funeral Service Licens		ر ما		2. Name an				Baltimo 1101 E	re,	Md.	21202
Physician	_	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused one cause on each lin aSEPSIS	ne.	Do not en	ter the mod	e of dyin	g, such as	cardiac o	or respiratory ari	est,		Approximate Interval Between Onset and Death DAYS
/Medical Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter linds right,	Due to (or as PELVIC Due to (or as) ABC	ESS								UNKNOWN
te be executed ysician and ne burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. SACRAL	DEC	UBIT	US U	LCEI	₹					UNKNOWN
ificate be executed g physician and as the burial-transit	edicai E		d DIABET	ES M	IELLI	TUS							YEARS
the death cert y the attendin	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	⊒Ectopic pr ⊒ Other (sp					2	3d. Date of Month	delivery Day Year
quires that n signed by uld be deta	by	Part II. Other significant conditions or LOBAR PNE		ut not resul	ting in the i	underlying c	ause giv	en in Part I		23e. Did to			e to the cause of death? Probably 4 Munknown
lor Attending Physicien: The law requires t after death. Director: After this certificate has been signed in by the funeral director, page 2 should be c	Completed	ATHEROSCI	EROSIS							24a. Was a autop perfor	sv	24b. Were prior death	e autopsy findings available to completion of cause of n? Yes 2 \(\text{No} \)
Icien: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Haspital				Oth	05		Check only or			
Physic this c	-T	1 Yes 2 No	Hospital: 1 Inpatie	ent 2 🗆 E	R/Outpatie			40140		me 5 Resid			Specify)
To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Da	y Year)	Injury	М		k? Yes 2□	No				r Rural Route Number,
bitel or Attendurs after death		4 Homicide determined	building, et	с. (Ѕреспу)						City or Tow	n, State)		
To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical		ysician: To the best iner: On the basis o and manner st	t examinati									
To tl withii To tl	Ň	29b. Signature and title of certifier	Printer	WO			D51	e number		-		signed (M	onth, Day, Year)
\	Q	30. Name and address of person who o		leath (Item		, Print) SLER	no:	IVE.	7 (3)	ISON. M	(A D)V	LAND	01000
	tate	31 Date filed (Month Day Year)	32 Registr	ar's Signati	ura		1/17.	AVE.	UN	DUIN, II	IFIX Y	L HNI)	21204
Regis	uar	JUN 1 1 2004	Rouse	1 15	No.	NO.							

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2001 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth Facility Neme (If not institution, give street and number) Examiner JIMOKE 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Hours Months Days 1□ M 2/XF 83 220-22-7646 Director 20 NC Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at XXYes 2 □ No Funeral Director Baltimore MD NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21229 U.S.A. <u>3610 Clarenell</u> Road 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes ※ ※ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: ð 3 □ Widowed 4 □ Divorced Black Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker House NA <u>12th grade</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Peges 1 end 2 should be fill timent of Health end Mental H tant: If Item 27 ie marked oth jury or other traumatic even Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3610 Clarenell Road, Baltimore Md Reginald L. Street-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Depertment of important: if any injury or 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 6/15/04 Arbutus, Md 22. Name and Address of Facility 21. Signature of Funeral Service Licen March F/H West 4300 Wabash Ave, Baltimore Md 21215 consthat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Physician CEREBRO VASCULAR HEROSCLEROTIC Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death cartificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ettending physical for use es the t Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown MELLITUS Medical Certification: To Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Vac 2010 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 412 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred **₩** Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours aftar death To the Funerel Director: A complately filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MILONER 30 Name end eddress of person who completed cause of death (Item 233) (Type, Print) 7220 31. Dete filed (Month, Day, Year) 32. Registrar's Signature JUN 1 1 2004 Registrar **DHMH 16 Rev 6/95**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** BENJAMIN STEIN JUNC 11 00 PM OB 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death city BALTIMOLE HUSPITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 214-34-4349 1 💢 M 2 🗆 F 91 Yrs. Director JUNE 30, 1912 MARYLAND Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f shoy other traumetic event, the Medical Examiner must be notified a MD BALTIMORE BALTIMORE 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 4 TYLER FALLS CT., APT. J 21209 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 0 1 ☐ Yes 2 ☐ No Specify: WHITE Specify: 3 Widowed 4 Divorced "natural" 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 in and Mental Hygiene.
7 is marked other than "r WHOLESALE PAINT College (1-4or 5+) Elementary/Secondary (0-12) MERCHANT & HARDWARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HARRY STEIN 2 REBECCA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health lem 27 BLANCHE STEIN (WIFE) 4 TYLER FALLS CT., APT. J BALTO., MD 21209 Department of Healt Important: If item 2 any injury or other once. Baltimore, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State * 4 □ Donation 5 □ Other (Specify) HAR ZION TIFERETH ISRAEL 6/10/04 ROSEDALE, MD 21. Signature of Funeral len ice Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) .Physician GRAM NEGATIVE BALTERIAL SEPSIS 24 hours /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Pieu nat conquitive HEART 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed RENAI 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? CARCINOMA COLONARY 3243E 1 ☐ Yes 2 ☑ No 1 Yes 2 VNo Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No 2 this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification; After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medicai 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D. 72=5-000 コレンモ 08 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FABE1210 CAIMI BALTIMORE PAOLO SINAL JATI 920H DE 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

JUN 1 1 2004

State of Maryland / Department of Health and Mental Hygiene 2 n Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Catalina Alejandro Solis <u> 11:11AM</u> JUNE 09 2004 /Medical 4c. County of Death 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LA PLATA CHARLES CIVISTA MEDICAL CENTER If Under 1 Year if Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 582**–**04–5353 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Days Months Hours 1 □ M 25 F 98 Director 30, 1906 San Juan, PR Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Items 23a or 28a-f show event, the Medical Examiner must be notified at Yes 2 No Completed by Funeral Director PR Carolina Valle Arriba Heights 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Calle Naranjo BO-11 00983 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22050 If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married "nstural", or Yes 2□ No Specify: Puerto Rican Specify. white 3€Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Own Business 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) it of Health and Mental Rosendo Solis Emilia Alejandro or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marlin Barreto / Granddaughter 67 Calle Campina, Carolina PR 00987 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ☐ Burial 2 ☐ Cremation 3 ☑ Temoval from State permit. Page Department of Important: If any injury or US National Cemetery June 14, 2004 Bayamon, * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc. 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 1501 East Fort Avenue, Baltimore Maryland 23a. Part1. Enter the disease, or complications that can shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) Examiner F Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury (or as a consequence of): Physician/Medical Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last and Box 68760, as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 menths?
1 2 Yes 2 2 No 23d. Date of delivery 3 Ectopic pregnancy ō Month Dav Year 4☐Pregnant at time of death 5 Other (specify) detached O 9 Unknown s been signed by I م 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 🗌 Yes 2 🗆 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has certificate 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 No 2 ER/Outpatient 3□ DOA 1 Tyes this 27. Manner of Leath 28a. Vate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after deatl To the Funaral Director: completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Momicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie D-0026262 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KLETMAN SAMUEL J. MD11711 LIVINGSTON ROAD FT WASHINGTON MD 20744 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUN 1 1 2004

MARVIN THORNTON Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNK 04-204 State of Maryland / Department of Health and Mental Hygiene 04 - 3709Reg. No. 2004 dap Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Marvin hornton 03, JUNE 2004 1:45a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 216-94-4911 1**9**M 2□F 39 September 13,1964 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho treumatic event, the McUlcal Examinor must be notified at 1 Yes 2 No Baltimore Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3911 Bonner Road USA 21216 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2 No Yes, Give 1 Never Married 2 Married 1□Yes 2☑No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Fender permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked ofth any injury or other treumatic event, 90x8. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ihornton -rankin Boone Iheresa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Road, Baltimone MD ZYZ/6 3911 Bonner I heresa Thornton/mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zron Cemeter 6/10/04 21. Signature of Funeral Service Ucensee

22. Name and Address of Facility
How 1 Co SC Funeral Service, PLA

1709 Tession St., Salthmore MP 2100+765

23a. Part 1. Enter the issease. In plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Immediate Cause (Final *4 □ Donation 5 □ Other (Specify) Immediate Cause (Final a. Asphylia and blunt holce injuries
Die to for as a consequence of): **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical the as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 ☐ Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 X Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 □ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes > No investigation June 3,2004 2 Accident 11:00 K Subject Assaulted after death Director: the 1 3 ☐ Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Street within 24 hours a To the Funeral D 4N. Central Ave, Bellimore, mei 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME ,2004 JUNE RIPPLE FOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

JUN 1 1 2004

TASMA

ZEMENS-GREENBERG MO111 Penn Street, Baltimore, Maryland 21201

32. Registrar's Signature

Aparlish

104

			State of Maryland / Dep	partment of Health and Mental Hy	giene
			1 - State Ragistrar 1. Decedent's Name (First, Middle, Last)	2. Date of De	Rag. No. 2004 8384
	Physici /Medic		Edward Earl Taft	June 8	3, 2004 Year 1:00 Am
	Examin		4a. Facility Name (If not institution, give street and number) 1101 Bonaparte Avenue	4b. City, Town, or Location of Death Baltimore	4c. County of Death
1	Funeral Director		5. Social Security Number 245-48-8176 6. Sex 1. M 2 F 7. Age (In yrs. last birthda. Yrs.	y) If Under 1 Year If Under 24 Hrs. 8. Date of Bi Months Days Hours Min. Feb. 4.	
	yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or		10d. Inside City Limits
	a Mar	i ct	nary rana 11722	imore	文录Yes 2□No
	th with the 23a or 2 ust be no	Funeral Directo	100. Street and Number 1101 Bonaparte Avenue	10f. Zip Code 21218	10g. Citizen of What Country? USA
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28e-f show or other traumatic event, the Medical Examinar must be notified at	by	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\subseteq \text{No if Yes} \(\subseteq \text{No if Yes} \) (Sive \(\text{Yes} \) (Siv \(\text{Yes} \) (Siv \(\text{Yes} \) (Siv \(\text{Yes} \) (Siv \(\text{Yes} \) (Siv \(\text{Yes} \) (Siv \(\text{Yes} \) (Siv \(\text{Yes} \) (Siv \(\text{Yes} \) (Siv \(\text{Yes} \) (Siv \(\text{Yes} \) (Siv \(\text{Yes} \) (Siv \(\text{Yes}	Was Decedent of Hispanic Origin? (Specify Yes or North Head of Hispanic Origin?) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) □ Yes 2 No Specify:	14. Race - American Indian, Black, White, etc. Specify: Black
15-0	"natura	leted	(Specify only highest grade completed) (Giv	cedent's Usual Occupation we kind of work done during most of working DO NOT use retired!	16b. Kind of Business/Industry
21215-0036	filed withir Hygiene. other then	Completed	Elementary/Secondary (0-12) College (1-4or 5+) ""6-	Plumber	E.J. Snyder, Inc.
Maryland	d be file antal Hy ced oth c event	Be	17. Father's Name (First, Middle, Last) Hillie Taft	18. Mother's Name (First, Middle Emma Little	
ary	2 should be f and Mental I la marked of raumatic eve	2	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or Rural Route Numb Bonaparte Avenue Bal	er, City or Town, State, Zip Code) 21218
	1 and 2 Health tem 27 I		Emma Holland/ Sister 1101 20a. Method of Disposition 20b. Place of Disp		20c. Location - City or Town, State
mor	Pages nent of h ant: If its ury or of		1 Removal from State cemetery, cr	rematory or other place)	Greenville, N.C.
Baltimore,	parmit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Livensee	22. Name and Address of FacilityChatman - I 5240 Reisterstown Rd I	Harris Funeral Home Baltimore,Md 21215
Ţ			23a. Part/ Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respiratory a	Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) aue to (or as a consequence of):	CARCINOMA OF the	Prostate Years
	ed sit	lner	Sequentially list conditions, if airy, leading to immediate cause. Enter Underlying Cause (Disease or injury		
o,	sician and burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):		
68760,	cate be ohysici the bu	dlcal	d		
P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	Physician/Med		B⊟Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
	ras that igned b	by Pr	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did	tobacco use contribute to the cause of death?
ord	w require been si should t	eted	FULMONARY EMBOLISM	1	, ,
Records,	The law ate has b page 2 s	Completed	CVA		psy prior to completion of cause of death?
Vital		Be Co	25. Was case referred to medical examiner?	26. Place of Death (Check only of	2 No 1 Yes 2 No
of V	Phyaician: this certific ral director,	မ	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati		dence 6 □Other (Specify)
		atlon	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury (Month, Day Year)		how injury occurred
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office 28f. Location (City or To	Street and Number or Rural Route Number, wn, State)
	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by th	Medical	29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, deal cartifying Physician: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and due to the nvestigation, in my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	To t To t com	2	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	ω		30. Name and address of person who completed cause of death (Item 23a) (Type	e. Pigg) 6 V6 Balhaca.	nd out
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature		an dist
DH	Registr MH 17 Rev 1/20	- 19	JUN 1 1 2004 Server &	Spals	
211	/ 1137 1/20		•		

ORIGINAL

			1 - For State Registrar	State of Ma	ryland / Dep		lealth and	Mental Hygie	ne 2001	1 1000
	Physici /Medio		1. Decedent's Name (First, Middle, Last Earl V. Wilh	elm				June 9	Day Year 2004	3. Time of Death
	Examir Funeral Director	er	4a. Facility Name (If not institution, give Long View Nursin 5. Social Security Number 212-16-3394	g Home	(In yrs. last birthday	Mano	chester If Under 24 Hrs Hours Min	8. Date of Birth	4c. County of Dea Carr par) 9. Bir Co Ma	
	D D	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Carrol	1	10c. City, Town or I		ancheste			10d. Inside City Limits 1 Yes 2X No
	th with the 23a or 28	ai Director	10e. Street and Number 4816 Alesia Road			10f. Zip Code	21102	10g.	Citizen of What Co	-
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other than *natural', or items 23e or 28e-f show any injury or other traumatic event, ite Medical Eratificat minalitie invitiliad at ance.	by Funerai	11. Marital Status 1 Never Married 2 Married X 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates:	0	B. Was Decedent of F If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit Specify:	
Maryland 21215-0036	within 72 ho iene. than "natur the Medical.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Giv	edent's Usual Occup to kind of work done DO NOT use retired Farrier	during most of wo d)	orking 16b	Black Sn	
yland 2	ould be fited Mental Hygi Merkad other	To Be Co	17. Father's Name (First, Middle, Last) Virgil R. Wilhel				Maria	me (First, Middle, Maid n Coefield		
, Mar	is 1 and 2 sh of Health and item 27 is m other traum		19a. Informant's Name/Relationship (T) Zelda Wilhelm, w		481	6 Alesia	Road, Ma	nchester, Date 200	MD 21102	
Baltimore,	Pages 1 ment of H lant: If ite		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		Wesley	position (Name of ematory or other place UM Cemete	ery 06/	12/2004	Location - City or Hampstea	
Ball	permit Depart Import any in		21. Signature of Puneral Service Licens	Dell	ul	22. Name and Addre	h Main S	Eline Fun St, Hampste		
100 miles 100 miles	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	consequence of):	nter the mode of dyin	ng, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
8760,	roate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, in any, leading to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	consequence of):					
.O. Box 68	he death certif the attending thed for use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death 3	☐Ectopic pregnancy	/		23d. Date of del Month	ivery Day Year
1	quires that the signed by and be detacted.	ed by Pr	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the	underlying cause giv	en in Part I.			the cause of death?
al Records,	i: The law requir icate has been si r, page 2 should I	Completed						24a. Was an autopsy performed 1 Yes 2	? prior to death?	itopsy findings available completion of cause of
Vital	siciar certif rector	Be	25. Was case referred to medical examiner?	Hospital:		Cth	00	ath (Check only one)		
Division of	To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	t 2 ER/Outpatie 28b. Time Year) Injury	of 28c. Injur	y at	Home 5 Residence		offy)
Divis	tal or Attend s after death al Director: A ed in by the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, s (Specify)	street, factory, office	- 3n-30r 2	28f. Location (Street City or Town, St	t and Number or Ru tate)	ıral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dirt completely filled in It	Medical (29a. Certifier 1 Certifying Phy (Check only one)	sicien: To the best of ner: On the basis of and manner state	examination and/or i	ath occurred at the tir investigation, in my o	ne, date and place pinion, death occ	e, and due to the cause urred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
•	To t To t	×	29b. Signature and title of certifier			29c. Licens	e number 33 1 6 5	29d.	Date signed (Monti	h, Day, Year)
	6x		30. Name and address of person who c	Sharter	- 2111	Print) anora	P:le	- Come to	steel wil	21074
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registra	's Signature	le le		, 3	,	

				1 - For State Registrar	e of Maryland / Dep	partment of Health and I	•	ne
				Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
		Physici /Medi Examir	cal	Celia V. Wilber 4a. Fecility Name (If not institution, give street and	i number)	4b. City, Town, or Location of Death	June	Day 2004 12,45 AM 4c. County of Death
	4	CXAIIII	iei	North Arundel Hospita		Glen Burnie		Anne Arundel
	T	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda		8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
		Director		056-10-0528 ^{1□ M 2} X	89 Yrs.	I I I I I I I I I I I I I I I I I I I	FEB. 14,	1915 New York
		and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
		Manyl 4 sho ied a	ō	N.Y. Suffolk	Stony Br	rook		1 ☐ Yes 2 ☐ No
		r 28a	rec	10e. Street and Number	CCOMY DE	10f. Zip Code	10g.	Citizen of What Country?
5		within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show tre Modical Examiner must be notified al	Funeral Director	5 Stony Brook Avenue		11790		USA
-		ems ems	iner	11. Marital Status 12. Was	Decedent Ever in U.S. 13 d Forces?	B. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - American Indian, Black, White, etc.
3	36	s afte	by Fu	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married	es 2∏No Give No	1 ☐ Yes 2 No Specify:	,	Specify: White
. ~	Ö	hour tural	ed b	3 X Widowed 4 □ Divorced Year 15. Decedent's Education	or Dates:	cedent's Usual Occupation	16h	. Kind of Business/Industry
3	5.	in 72 n" na	piet	(Specify only highest grade comple	ted) (Giv	ve kind of work done during most of wor . DO NOT use retired)	king	•
2	212	d with giene. r thai	Completed	Elementary/Secondary (0-12) Colle	ge (1-4or 5+) Secr	etary	1	Brookhaven National Lab
Wilber	bu	e file al Hyg l'othe vent,		17. Father's Name (First, Middle, Last)		18. Mother's Nan	ne (First, Middle, Maid	len Sumame)
3	<u>ya</u>	Menta Menta arked	To Be	Alexander Jackim		Anna Ada	mowicz	
	Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship (Type, Print,		iling Address (Street and Number or Ru		
		permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic event, Ite Medical Examinar must be notified at once.		Lora Ann Espersen - d		Cypress Landing R		
	Baltimore,	iges in ite		1 Burial 2 □ Cremation 3 □ Removal f	OIII State	position (Name of ematory or other place)	1,	. Location - City or Town, State
	Ħ	it. Pa irtmer irtant njury		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Ligensee		National Cem. 6/1 22. Name and Address of Facility	4/2004 P	Pinelawn, N. Y.
	Ba	permi Depar Impor any Ir					eral Home (Meadowridge MP, Inc.
				23a. Part 1. Enter the disease, or complications to	nat caused the death. Do not e	250 Washington BLV inter the mode of dying, such as cardiac	 C., Elkrid or respiratory arrest, 	ge, MD 21075 Approximate
		Physician		Immediate Cause (Final	on each line.	heumonia		Interval Between Onset and Death
	7	/Medical		disease or condition resulting in death)	e to (or as a consequence of):			
		Examiner		Simulatian Set a published	evelovovascu	In Accident		
		P #	iner	cause. Enter Underlying	e to (or as a consequence of):			
		ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	a to (or as a consequence of):			
	60,	be ex ician burial	icai E	3	s to (or as a consequence or).			
	Box 68760,	death certificate e attending phys ed for use as the		d				
	×C	death certifical attending phy of for use as th	/Me		, outcome of pregnancy			23d. Date of delivery
	ğ	death a atter	iciai	in the past 12 months?	regnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month Day Year
	P.O.	the by the tache	Physician/Med	9 ☐ Unknown 9☐ U	nknown			
		iaw requires that the death as been signed by the atte 2 should be detached for	by P	Part II. Other significant conditions contributing	to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
	of Vital Records,	equir sen si ould I					1 🗆 Yes	2 No 3 Probably 4 Munknown
	ec	faw ras be	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	H	: The cate h	S				performed	
i	Vita	ding Physician: The law h. After this certificate has t funeral director, page 2 s	Be	25. Was case referred to medical examiner? Hospital:	/	Othor	th (Check only one)	
X	of	Phy ral o	- To	I Tes 2 INO	Inpatient 2 ER/Outpatient of Injury 28b. Time	ant 30 DOA 40 Not sing in	ome 5 Residence 28d. Describe how in	6 □Other (Specify)
	on	ding th. : Afte	tlon	1 Matural 5 Pending (date of Injury Month, Day Year) 28b. Time Injury	of 28c. Injury at Work? M 1 Yes 2 No	204. 20000007	jary occurred
	Division	Attanding r death. actor: After by the fune	ifica	a Could not be	lace of Injury - At home, farm, suilding, etc. (Specify)	street, factory, office		and Number or Rural Route Number,
	Ö	s afte	Certification:	4 Homicide	uilding, etc. (Specify)		City or Town, Sta	1(0)
		To the Hospital or Attano within 24 hours after death To the Funeral Director: completely filled in by the	edical ((Check only 2 Medical Examiner: On t	the best of my knowledge, deane basis of examination and/or manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
		o the other or the omple	Med	29b. Signature and title of certifier	A A	29c. License number	29d. [Date signed (Month, Day, Year)
		- s + o		1 Doone & M	hills I n	D. 041365	Ju	ne 9, 2004
		M		30. Name and address of person, who completed	cause of death (Item 23a) (Type	e, Printy	/1 D	- MN 71473
						1 A REPUTAL Drive	, Glen Di	INNE, FID. 2106/
		Sta Registr		31. Date filed (Month, Day, Year)	2. Registrar's Signature	Spake		

				nd / Departmer 5832 ,067 II / 0 Certificat		2. Date of De		3. Time of Dear
Physici	an	Decedent's Name (First, Middle, Last	st)	\0		Month	Day Year	
/Media		WILLIAM	14.		TOWN, or Location of De		4c. County of Deet	
Examir	ner	4a. Facility Name (If not institution, give					AC. County of Deet	n
	4	Johns Hopkins Br. Social Security Number 6.5		001010-	ALTIMOR E		th 9 Birth	hplace (State or For
uneral irector			XM 2□F 84	Yrs. Months			iv. Year) Co	MD.
AC III		10a. State 10b. County	10c. 0	City, Town or Location				10d. Inside City Lir
ral, or items 23a or 28a-f show Extended must be mailified at	to	MD. W/	7 7	BALTIMO	VE			1 2 Yes 2 □
288	Funeral Director	10e. Street and Number			Code		10g. Citizen of What Co	untry?
38 0	0	801 C (1)	INTON S	7	21224		U.S. A	
TIS 2	era	11. Marital Status	12. Was Decedent Ever in	U.S. 13. Was Dece	dent of Hispanic Origin? city Cuban, Mexican, Pu	(Specify Yes or No	- 14. Race - Ame	
P de	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No	100		erto Rican, etc.)		e, etc.
o',	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify: W	HITE
"natural", dical Ex	Completed	15. Decedent's E		16a. Decedent's Usu	al Occupation ork done during most of w	working.	16b. Kind of Business/	Industry
r than "natu	pie	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	ise retired)	OTKING	1 1	,
	Ю	6 TH		SHOP			CAN C	g .
d other	Be C	17. Father's Name (First, Middle, Last,)		18. Mother's N	lame (First, Middle	, Maiden Sumame)	
	To	William H.	WILKE	. SR.	MAR	GARET	P. HiN	E5
Item 27 is marke other traumatic		19a. Informant's Name/Relationship (19b. Mailing Addres	s (Street and Number or	Rural Route Numb	er, City or Town, State, 2	Cip Code) Z/ZZ
27 l		ALMA M. K)	LKE	8065.0	CLIPTON	57= 2	3ALT MIKE 20c. Location - City or	E MD.
r othe		20a. Method of Disposition	20b.	Place of Disposition (Na cemetery, crematory or	me of other place)	Date 27	20c. Location - City or	Town, Stete
- 0		1 Burial 2 □ Cremation 3 □ 1 Donation 5 □ Other (Specif	Jramovai nom State 📗 🥖	SARDENS O		20174	BALTO. 1	Mr.
ortant injury 8.		21. Sonature of Paor ral Service Lice			nd Address of Facility	28291	TUDSON 3	
eny ir		et homas.	Skarle	- SKAR	DI2 F. H.	BAITO		224
sician	15. 1	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de	ath. Do not enter the mo	de of duing such as card	iac or respiratory	rrest A A	Approximate
ledical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conse	HEAD	BLEED			Interval Betwee Onset and Dea
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Peter Zornak 04-3837 AKG

3837			State Unpend Item	State of Ma n #23a,27,28	ryland/ Ba-f pe	Depa Cel	artment of F	lealth and I 28/04 ta	Mental Hy S	giene Reg. No 2001	18388
	Physici		1. Decedent's Name (First, Middle, L PETER E	ast) UGENE	ZORNAK	JR.			2. Date of De. Month June	Day Year	3. Time of Death 5:51 P M
	/Medic Examin		4a. Facility Name (If not institution, g					r Location of Death		4c. County of De.	
2	Funeral Director		1357 Cambria Av 5. Social Security Number 6. 212-58-9129		(In yrs. last t	oirthday) Yrs.	Baltimo If Under 1 Year Months Days		8. Date of Birl (Month, Da Sept.0	ıy, Year)	rthplace (State or Foreign Country) ryland
1)	ow st		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation	·			10d. Inside City Limits
:	the Marylandr 28e-f show	Director		n/a	Ba1	timo					1 X Yes 2 □ No
	death with the Maryland ms 23s or 28e-f show mast be it difficulat	ai Dire	10e. Street and Number 1357 Cambria St	reet			10f. Zip Code	1225		10g. Citizen of What C	•
	urs after deat al', or Items ? Evantiner nu	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			Vas Decedent of F f Yes, specify Cuba 1 ☐ Yes 2 ☐ No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after de, if Heath and Mental Hygiene. Itam 27 is marked other than "netural", or llems other traumatic avant, the Medical Eventrein	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5-	+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired	oation during most of wor d)	king	16b. Kind of Busines Anne Arun Board of	del Co.
land 2	uid be filed Aental Hygie rked othar tic avant,	To Be Co	17. Father's Name (First, Middle, La Peter E.				endirec			, Maiden Sumame) DYCE	
	of 2 shorth and N		19a. Informant's Name/Relationship Denise D. Zorna)	9b. Mailir 1521	ng Address <i>(Street</i> Battery	and Number or Ru Ave. Ba	ltimore,	er, City or Town, State, Md. 21230	Zip Code)
Baltimore,	Pages 1 ar nent of Hea int: If itam iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 1 ☐ Donation 5 ☐ Other (Spec		cemet	tery, crer	sition (Name of natory or other plac Cremator		Date 1/2004	20c. Location - City of Baltimore	
Balti	permit. Pages 1 Department of H. Important: If ital any injury or ott		21. Signature of Funeral Service Lic	mase	122	22	Name and Address McCull 130 E.	ss of Facility y Polynia Fort Ave	ak Funer e. Balti	al Home P. more, Md.	A. 21230
	/Medical // // // // // // // // // // // // //	dical Examiner	23a ant. To the sease or to shock, or heart failure. List on Immedia. Cause (Fin disease or resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		le Hydi consequenc	e of):		ntoxicati			Onset and Death
	The faw requires that the death certificate tte has been signed by the attending physoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at the 10 □ Unknown	2 🗌 Fetal dea		Ectopic pregnancy	′		23d. Date of de Month	blivery Day Year
ds, P	furres that n signed b ald be deta	þ	Part II. Other significant conditions	contributing to death bu	t not resulting	in the u	nderlying cause giv	ren in Part I.		obacco use contribute Yes 2 □ No 3 □ F	to the cause of death?
		Completed									utopsy findings available completion of cause of
Vital	Physician: 1 r this certificat ral director, p	o Be	25. Was case referred to medical examiner? 1 ∑xes 2 □ No	Hospital:	nt 2 ER/C	Outnatien	t 3 DOA Oth	or	th (Check only o		ecity) At scene
n of	ding Phy h. After thi funeral c	on: T	27. Manner of Death 1 Natural 5 Pending	Pourier th, Day	/ 28b	. Time of	at 28c. Injur	y at k?		now injury occurred	Sony) 110 DOC-1
	or Attan ifter deat Siractor: in by the	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide				D	Yes 2 No	Unkno 28f. Location (S City or You Baltimo	own Street and North 57 F wn, State) Ore, Maryla	Cambria Ave. Ind
	Hospita 4 hours Funaral ely fillec	edical C	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner state	f my knowled examination a	ge, death	occurred at the tirvestigation, in my c	ne, date and place pinion, death occu	, and due to the	cause(s) and manner a	s stated.
	To the within 2 To the complet	Me	29b. Signature and title of certifier		. 0 -		29c. Licens			29d. Date signed (Mon	
,			30. Name and address of person wh	o completed cause of de	ath (Item 23a	i) (Type,	O.C.M	.E.		June 10,	2004
			ZAB/UCCI 31. Date filed (Month, Day, Year)	914 A 32. Registra	r's Signature		111 Pe	nn Street	t, Balti	more, Mary	land 21201
18	Sta Regist		JUN 1 1 2	10.	rs signature	L	all I				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Doris Evelyn May Bingham 24 2004 3:45AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Westminster Nursing & Rehabilitative Ctr. Westminster Carroll If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 21 F Months Deys 93 115-32-6111 Dec. 11, New York Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 KYes 2 No Maryland Carroll Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 130A North Main St. 21791 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 → Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) farm wife dairy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sylvester E. Lounsberry Florence Hemingway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon L. Osborn/ daughter P.O. Box 88 Keymar, MD 21757 20b. Place of Disposition (Name of cemetery, crematory or other place)

All County Cremation

22. Name and Address of Fecility

6 E. Broadway

D-0054218

20c. Location - City or Town, State

Sykesville, MD

Approximate Interval Between Onset and Death

29d. Date signed (Month, Day, Year)

MD 21157 DR. KANERTA

Union Bridge, MD 21791

5/25/04

Hartzler Funeral Home

permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 Is marked other any Injury or other **Physician** /Medica Examine

Physician

/Medical

Examiner

10a. State

20a. Method of Disposition

1 ☐ Burial 2 Ø Cremation 3 ☐ Removal from State

4 □ Donation 5 □ Other (Specify)

21. Signature of Funeral Service License

Director

Funeral

Š

Be Completed

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at

the Maryland

filed within 72 hours after death with

Baltimore, Maryland 21215-0020

To the Hospital or Attanding Phys within 24 hours after death.

To the Funeral Director: After this complately filled in by the funeral di

or Attending Physician: The law requires that the death cartificate be executed Division of Vital Records, P.O. Box 68760,

shock, or heart failure. List only or	e cause on each line.	Inte	rval Between set and Death		
Immediate Ceuse (Final disease or condition resulting in death)	Metastate Canc	er Lyng			
Sequentially list conditions,	Due to (or as a consequence of): Due to (or as a consequence of):	0			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions con	Due to (or as a consequence of): Machael Deg. O	} Eyes			
Part II. Other significant conditions con	tributing to death but not resulting in the underlying cause given in Part I. A - D,	23b. Did tobacco use contribute to the	cause of death?		
p. ,	A.F.	performed? available	utopsy findings le prior to tion of cause 1?		
Din	erticulosis	1 □ Yes 2 □ No 1 □ Yes	s 2□No		
25. Was case referred to medical examiner?		eath (Check only one)			
1 1 165 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. Manner of Death 1	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury M 28c. Injury et Work? 1 Yes 2 No	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, efc. (Specify)				
	ician: To the best of my knowledge, death occurred at the time, date and placer: On the basis of examination and/or investigation, in my opinion, death occurred manner stated.				

who completed cause of deeth (Item 23e) (Type, Print)

32. Registrer's Signature

State Registrar

0

29b. Sigg

30. Name

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 4:36 Mai 2004 William /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** City Battmore
If Under 1 Year If Under 24 Hrs. HOPKINS tospita Johns 8. Date of Birth (Month, Day, Aug. 19, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Min. Hours 1**⊠**M 2□F Yrs Director 82 Aug. Maryland 216-16-3753 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🙀 No Director Harford Street MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21154 3537 Prospect Road Funeral Items 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 20 Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White δ 3 Widowed 4 □ Divorced WWII natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) Farming 12 Dairy Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt.
Department of Health and Mental Hy
important: if item 27 is marked oth
any injury or other traumatic event Be Louise Nelson Oliver P. Boyer, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20016 3725 Alton Place, NW Washington, DC William W. Boyer, Jr. (son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Perryman, Maryland Spesutia Cemetery 6/1/04 * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399 once. 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) muocardial intarction Pnysician 2 hours /Medical Due to (or as a consequence of) **Examiner** hours FIDE tria if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine embolism vimonar and Due o (or as a consequence of): physician at s the buriat-t Box 68760 certificate be Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1 Yes 2 □ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. М investigation 2 Accident within 24 hours after death To the Funeral Director: the 1 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide ō filled 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0058637 May ,7004 ms +1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21287 Johns Hopkins Hospital 600 North Wolfe Street Baltimore Maryland Pati Susheel

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN

ORIGINAL

lan & food

32. Register's Signature

2004

	•	1 - For State Registrar	State of Mar			nt of H	ealth ar		ental Hy	giene Reg. No. 2	004	1.8	39
Physici /Medic	al	Decedent's Name (First, Middle, Last, Laura Jacquelin 4a. Facility Neme (If not institution, give	e Buren		4b. City.	Town, or	Location of		2. Date of Dea Month May	24	2004	3. Time of 8:45	Death P N
Examin	er	Anne Arundel Medi 5. Social Security Number 6. Se	cal Center	In yrs. last birthday 39 Yrs.		r 1 Year	If Under 24	olis	8. Date of Birt (Month, Day Jan 2	Anne	Aruno	lel tace (State of try) insylva	r Foreig
Director Moyou	٥٢	Usual Residence of Decedent 10a. State Maryland Anne Aru	1	Oc. City, Town or L		Annar	∞lis		Jan. 2	.0, 191		Od, Inside Cit	ty Limi
hours after death with the Maryland tural, or Itama 23a or 28a-f ehow at Erann or itual ou indified at	Direct	10e, Street and Number 930 Beacon Way				Code	21401			10g. Citizen o		try?	
o within 7.2 flours after death with the marylar jiene. Jiene Triban "natural", or itame 23a or 28a-f ehow the Medical Examinational be inclifted at	by Funerai	11. Marital Status 1 Never Married 2 Married 3CSWidowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2/2/No If Yes, Give Year or Dates:	er in U.S. 13.	Was Dece If Yes, spe 1 Yes			in? (Spec Puerto R	cify Yes or No- lican, etc.)	В	ace - Americ tack, White, city: Whi	etc.	
r than "na	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(Give	DO NOT	ork done d ise retired)	uring most o				Business/Ind		
atal Hyg	To Be C	17. Father's Name (First, Middle, Last) Jan Damrowski	ma (Print)	10b Mail	line Address	s (Street a	Mari	a Pa	me (First, Middle, Maiden Surname) Palacha fural Route Number, City or Town, State, Zip Code)				
Health and hm 27 Is m ther traum		19a. Informant's Name/Relationship (T) Ronald Buren/son 20a. Method of Disposition		1611 20b. Place of Disp	3 Gri	st Mi	ll Dr	. F	Rockvil		2085	5	
Department of Importent: If its any injury or or one		1 Burial 2 Cremation 3 6 4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licent	1	# /	22. Name a	nd Addres	s of Facility	John	'2004 M. Ta er St.	ylor F	uneral	Home	 101
Physician //Medical //Medical //medical //wasit //wasi	cal Examiner	23a. Pert1. Enter the disease, or comp shock, or heart failure. List only of the disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitted events resulting in death) Last	Due to pras a c	consequence of):	bul	lat	lar	ac	ider	<i>x</i>		day	
rife law requires that the beant betrincate tile has been signed by the attending phys bage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 12 No 9 □ Unknown	d	Fetal death 3	□Ectopic p						Date of delive Month	•	/ear
wrequires inate been signed by should be deta	by	Part II. Other significant conditions co	ntributing to death but	not resulting in the	underlying	cause give	n in Part I.	383880		obacco use co res 2 No			
	Completed		24a. Was an autopsy performed						sy	24b. Were autopsy findings avail prior to completion of cause death? 1 Yes 2 1 No			
this certificate	Be	25. Was case referred to medical examiner?	Hospital:	- Cano	-0-	_ Othe			(Check only o				_
r this ral dil	ation: To	1 Yes 2 No 27. Munn of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28c. Injury at Work?							<i>'</i>)			
in b	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	(Specity)					8f. Location (S City or Tox	vn, State)			ber,
Fune Fune stely f	Medicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of iner: On the basis of eand manner state	xamination and/or i	ath occurred investigation	n, in my op	e, date and inion, death	piace, ai	d at the time,	cause(s) and i date and place	manner as st e, and due to	ated. the cause(s)	,
i o the Hospitel within 24 hours a To the Funerel I completely filled	Me	29b. Signature and title of certifier	is Ms	2	1	PS License	number	1	5	29d. Date sign	ned (Month,)	Day, Year)	
		30. Name and address of person who of Dr. Hung navis	ompleted cause of dea 2001 Medi			Annaı	∞lis,	. Mar	vland	21401	/	/	
Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	A 10								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydione

			State of Maryland / Department of Health and N Certificate of Death	, ,	iene eg. No.2 () () ()	10000
			1. Decedent's Name (First, Middle, Last)	2. Date of Deat	th	3. Time of Death
	Physic		Clifton T. Brown	Month Mav 19	Day Year	3:30 am
	/Medi Exami		4a Facility Name (If not institution, give street and number) 4b. City, Town, or Lo	-	4c. County of Dea	
Å			Crofton Convalescent Center Crofton		Anne Arı	indo1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8 Date of Birth		thplace (State or Foreign
	Director		215-18-4543 15tM 2□ F 82 Yrs. Months Days Hours Min.	(Month, Day,	7 1921 Ma	
	ъ.		Usual Residence of Decedent	111002	7 1 9 2 1 Ma	тутапо
	with the Maryland a or 28a-f show be notified at	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Ba-fa	Funeral Director	Maryland Anne Arundel Annapolis			1 ☐ Yes 2√∑tNo
	or 2	Oire	10e. Street and Number	10	0g. Citizen of What Co	ountry?
	23° ×	a	2001 Allis Street 21401		USA	
	ems	E I	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, Whit	rican Indian,
2	or in	F	1 Never Married 2 Married 1 No If Yes Give 1 Ves 2 No Specific	,,	Specify: B]	•
00	ural',	d by	3 Widowed 4 Divorced Year or Dates W • W • I I		ореслу. Б	ack
5	ed within 72 hours after death with the Maryland ygiene. Fer then "netural", or Hems 23a or 28a-f show it, the Medical Examinat must be notified at	Be Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work) If the DO NOT use retired)	ing	16b. Kind of Business	Industry
12	withi ene. then	μď	Elementary/Secondary (0-12) College (1-4or 5+)		Anne Arur	
9	be filed within tal Hygiene. d other than '	ပိ	12th 8 yrs. Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name			Education
an	d be ed o				•	
Maryland 21215-0020	d 2 should be filed v th and Mental Hygie 7 is marked other t treumatic event, the	ဥ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	e A. Bi		Zin Code l
Z	d2 street					
ē,	of Heal	ŀ	Rhonda Brown (Daughter) 6001 Westbrooke Dr. 20a. Method of Disposition CRIBURIAL 2 Occupation 3 December 120b. Place of Disposition (Name of commetery, crematory or other place)	New Ca	errollton 20c. Location - City or	Md . 2078
0	ages int of t: if it		© Burial 2 Cremation 3 Removal from State Hill Crest Cemetery 5		Annapoli	
Baltimore,	artmen ortant: injury		4 □ Donation 5 □ Other (Specify) ☐ TIT CTEST CEMETERY ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	/ 2 3 / 0 1	HIIIGOOTI	.b, ma.
Ba	permit. Pages Department of Important: if it eny injury or once.		Wm. Reese & Sons	Mortua	arv, P.A.	
			Larry J. Deese Mocy83 821 West St. Ann	apolis.	Md 214	01
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	r respiratory arre	st,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final	4	i	Onset and Death
	Examiner		disease or condition resulting in death) a. Metustatic Ierminal Blade	Me Ca	mcer	years
	/4	E.	Immediate Cause (Final disease or condition resulting in death) a. Me tostatic Terminal Blade Due to (or as a consequence of): b. Lynestensive Caucho Vas Culo	-		0
	uted d ansit	E I	o stype tennie androvouscula	MDIS	stan	years.
ς,	The law requires that the death certificate be executed ale has been signed by the attending physician end page 2 should be detached for use as the buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of):		1	
68760,	e be /sicia e bur	edlcai	Cause (Disease or injury that initiated events page 1 and 1			
	tificat ig phy as th	8	resulting in death) Last			
Вох	ndin use	₹	d			
	death e atte d for	icia I	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	22h Did tok	anna una anna-ihuta	to the cause of death?
P.0	t the by th	hys	The state of the s	1 ☐ Ye	_/	obably 4 ☐ Unknown
	s tha gned se de	by Physician/			2000 000	obably 4 olikilowii
Records,	w requires that the death cer been signed by the attendin should be detached for use	g		24a. Was an	autopsy 24b.	Vere autopsy findings
ပ္က	s ber	Completed		perform		vailable prior to ompletion of cause f death?
	The la	E		1 ☐ Yes		□Yes 2□No
of Vital	ician: The certificete rector, pag	Bec	25. Was case referred to medical 26. Place of Death		/ \	
f <	Physician: this certific ral director,	ToE	examiner? / Hospitali		nce 6 □Other (Spec	ifu)
0	g Ph erthi		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2	8d. Describe how		
<u>0</u>	Attending or death. ector: After by the fune	atio	2 Accident investigation M 1 ☐ Yes 2 ☐ No			
Division	er de recto	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2	8f. Location (Stre	et and Number or Ru	ral Route Number,
	tal or	Ce	- Striding, Oct. (Specify)	Oily or rown,	Jiaie)	
	lospi t hou uner uner	edical Certification:	29a. Certifier (Check only one) To the best of my knowledge, death occurred at the time, date and place, a death occurred at the time, date and place, a death occurred at the time, date and place, and other occurred at the time, date and place at the time, date and other occurred at the time, date and place at the time, date and place at the time, date and other occurred at the time, date and the time, date and other occurred at the time, date and the time, date an	nd due to the cau	use(s) and manner as	stated.
	To the Hospital or Attending Physician: The law within 24 beton after feath. To the Funerel Director: After this certificete has completely filled in by the funeral director, page 2		and mariner stated.	u at the time, dat	e and place, and due	to the cause(s)
	To To	Σ	29b. Signature and title of certifier 29c. License number		d. Date signed (Month	
			MAKUSH arolamy D2010	8	5/24	107
			Kakush and AMD D2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. ARORA 14300 Gallant Fox La, Ste.		0	11
			DR. HRORA 14300 Gallant tox La. Ste.	221 B	Sowjejli	14.207/5
	Sta		31. Date filed (Month, Day, Year) 32 degistrar's Signature			
	Registr	¢ .	MMI W LOUT ASSESSED AN ANGEL I			

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Year **Physician** /Medical 4b. City 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. ounty of Death **Examiner** If Under 1 Year If Under 24 Hrs. trunder Ical enter Hrundel 8. Date of Birth — (Menth, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace **Funeral** 1 M 2 F Days 213-30-9709 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits , or Items 23a or 28a-f show injury or other traumatic event, it a Mcdical Examiner must be notified at 1€ Yes 2 No Director 11 and Anne DOIL anna et and Number 10e. Site 10f. Zip Code 10g. Citizen of What Country? 1401 0 Stree death v Funeral 1000 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. filed within 72 hours after Hygiene. Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 1 No Specify: Black ğ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) andsc Unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If item 27 Is marked or mnle di 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Conf. or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place Jackson 20c. Location - City or Town, State 20a. Method of Disposition 1 🗆 Buriah 2 Cremation 3 Removal from State 5 ☐ Other (Speqfy) 4 Domation 21. Signature of Funeral Service 22. Name and Address of Facility plic tions that caused the death. Approximate Interval Between Onset and Death Do not enter the mode of dving fuch as cardiac or repiratory arrest, Immediate Cause Final di sas o condum resulting in death) **Physician** Due to (or as a consequence 1): /Medical Examiner Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury The law requires, that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last signed by the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? Day Year 5 Other (specify) □Yes 2□No detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 🗆 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2/2 this certificate 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitat 일 Other: Lipatient 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3□ DOA 27. Mapner of Peath Date of Injury (Month, Day Year) 28b. Time of 28a. 28c. Injury at Work? 28d. Describe how injury occurred 5 Pendina Natural investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: filled in by the funeral after death. I Director: After t within 24 hours a To the Funeral D

Certification: Medical

4 Homicide

29b. Signature and title

31. Date filed (Month, Day, Year)

29a. Certifier

State Registrar 30. Name and address of person completed cause of death (Item 23a) (Type, Print)

32. Reg trar's Signature

M V

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month/ Day, Year)

0

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Dav Month Physician Mina Esther Blumenthal 2;00 a M June 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore 19907 York Road Parkton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan . 27, 1909 9. Birthplace (Stete or Foreign Country)
Poland **Funeral** Days Months Hours 1 □ M 2 XF 577-16-3964 95 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show other treumatic event, the Medical Examinar court be notified at Parkton 1 ☐ Yes 2X No Baltimore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21120 19907 York Road or Itama 23a Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2XNo 3 Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Retail Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Eva Vatapsky Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Soots / Daughter 19907 York Road, Parkton, MD 20b. Place of Disposition (Name of Commeter), crematory acother place). Wiseburg United Methodist Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition Department of P Important: If Ite any injury or of once. June 6, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State White Hall, MD 2004 * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA1 Approximate Interval Between Onset and Death 23a. Part1. Emer the disease, or complication shock, or heart failure. List only one ca t a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Physician resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause [Disease Firition) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner ending physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 □ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day į Month Year 4 Pregnant at time of death 5 Other (specify) be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 3 Probably 4 Unknown cate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? certificate 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home Sesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ CO Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) In by 4 Homicide To the Hospitel filled Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1() rson who completed cause of death (Item 23a) (Type, Print) 3629 LUND CORNER RUMOD WHITE HAT I MD 21161 1+16AV.12 () SUNJUST 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

	2		1 - For State Registrar	State of Maryland	d / Department of Health and Certificate of Death		10. 2004 18395
	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Last) NICEY LILLIAN 4a. Facility Name (If not institution, give s	BURTON WHYT	ING 4b. City, Town, or Location of Deat	2. Date of Death Month D 2.	3. Time of Death 2004 3.00 A M
	Funeral Director	18. mg	SPA CREEK CENTER 5. Social Security Number 6. Sex 10 10 10 10 10 10 10 10 10 10 10 10 10		ANNAPOLIS, MAF ast birthday) Yrs. ANNAPOLIS, MAF If Under 1 Year Months Days Hours Min.	8. Date of Birth	ANNE ARUNDEL 9. Birthplece (State or Foreign DECAWARE
	be filed within 72 hours after death with the Maryland hall bygiene. Id other than "natural", or Items 23e or 28e-f show event, the Medical Evaninal must be routified at	ai Director	Usual Residence of Decedent 10a. State	NDEL AR	NOLD 10f. Zip Code 21012	10g. C	10d. Inside City Limits 1 □ Yes 2 1 No Citizen of What Country? US
5-0036	72 hours after dea natural', or Items dical Examinat m	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ∐Yes 2 2 No If Yes, Give Year or Dates:	S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
)-CLZLZ	d within 72 h giene. er than "natu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2	cation e completed) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) HOMEMAKER	rking 16b.	Kind of Business/Industry
ryland	hould be filed id Mental Hygi marked other matic event, I	To Be (17. Father's Name (First, Middle, Last) HARRY C. BURT 19a. Informant's Name/Relationship (Typ.			ne (First, Middle, Maide ORWOOD BU	JRTON
more, ma	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 Is marke any injury or other treumatic once.		EFFIE M. DESHIEL 20a. Method of Disposition 1 Description Descriptio	LDS/SISTER 20b. Pl	404 golf Course Co lace of Disposition (Name of ametery, crematory or other place) ael UM Church 5/25	urt Arnol Date 20c.1	
Baltimo	permit. Departn Importa any inju		21. Signatur, of Fyneral Service License	Meller	22. Name and Address of Facility Mi 19 Autumnwood Wa	ller Fune y Lewes,	eral Services
78	death certificate be executed Water and Medical and Medical and for use as the burial-transit	dicai Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	e cause on each line.	bet the planty ience of):	dine	Interval Between Onset and Death
O. Box ea	uires that the death certifica signed by the attending ph d be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
cords, P	The law requires that the ate has been signed by the page 2 should be detache	by	Part II. Other significant conditions conf		co use contribute to the cause of death?		
vital Rec	an: The law require Inficate has been sig tor, page 2 should b	e Completed	25. Was case referred to medical		26 Place of Dea	24a. Was an autopsy performed? 1 Yes 2 No. 1	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
sion of VI	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ation: To B	examiner? 1 Yes 2 No Ho 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	6 □Other (Specify) ijury occurred			
<u> </u>	spital or Atte ours after de ieral Directo filled in by ti	Il Certification:	3 Suicide 6 Could not be determined	building, etc. (Specify,	me, farm, street, factory, office) wledge, death occurred at the time, date and place	City or Town, Stat	
	To the Ho: within 24 h To the Fur completely	Medical	(Check only one) 29b. Signature and title of certifies 30. Name and address of a rson o cor	eer: On the basis of examination and manner stated.	29c. License number	rred at the time, date an	nd place, and due to the cause(s)
6	Sta Registr		31. Date filed (Month, Day, Year)	32. Registro's Signate	B D. Danah Orive C	herte. M	12/4/9

DHMH 17 Rev 1/2001

ORIGINAL

	10		1 For State Registrar	State of Mary	land / Depa <i>Ce</i> a	artment of F	lealth and I Death		iene 2004	18396
	Physic /Medi		Decedent's Name (First, Middle, Last	NORBERTO	ABALLO		2. Date of Death Month	Day Year	3. Time of Death 4 11:46 F	
	Exami		4a. Facility Name (If not institution, give Saint Joseph 5. Social Security Number 6. S	Medical Ce		4b. City, Town, o	Tows) Ti	4c. County of Dea	
	Funeral Director		· ·	ØM 2□F 6	yrs. last birthday) 1 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 2/6/19	rear) C	thplace (State or Foreign ountry) IRTO RICO
	he Marylan 8a-f show	ector	MD CARRO		City, Town or Lo					10d. Inside City Limits 1X2 Yes 2 □ No
	th with t	Funeral Director	100 Street and Number 107 HIGH ST.			10f. Zip Code 2177	6	10	g. Citizen of What Co USA	ountry?
9600	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show it Mudical Exeminer must be inclifted at	þ	11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Pueric Specify: PUE	Pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit AN Specify: W	
21215-	0 0 =	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 1 0	ucation de completed) College (1-4or 5+)	(Give	lent's Usual Occup kind of work done o DO NOT use retired LANDSCA	ation during most of work I)	ring	6b. Kind of Business,	•
re, Maryland 21215-0036	d a b	To Be			RABALLO		JUA		ODRIGUEZ	
	tand 2 s Health ar tam 27 is othar trau		19a. Informant's Name/Relationship (7 DEBRA CRUNKILT) 20a. Method of Disposition	ON in-Lay	W 2760	ROWE R	D., NEW	WINDSOR	City or Town, State, 2 MD . 21 Oc. Location - City or	776
Baltimore,	permit. Pages Department of I Important: If it any injury or o		1 ☐ Burial 2X Cremation 3 ☐) А.	L COUNT	natory or other place TY CREMA Name and Addres	Δ TI ϕ N 5/	26/04 s	YKESVILI UNERAL H	E, MD.
B)	40 E # 9	5 7	23a. Part1. Bote the disease, or comp	lications that caused the d	25	54 E. MA	IN ST.,	WESTMIN	STER, MD	21157 Approximate
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. ISCHEMIC Due to (or as a cons	CARDIO					Interval Between Onset and Death
30,	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons						
68760,	ificate b g physic as the b	edical		d						
.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1□Live birth 2□F 4□Pregnant at time o 9□Unknown	etal death 3 1	Ectopic pregnancy Other (specify)			23d. Date of deli-	very Day Year
rds, P	w requires that been signed b should be deta	5	Part II. Other significant conditions co END STAGE RENAL I		resulting in the un	derlying cause give	n in Part I.	III .	cco use contribute to 2 XNo 3 ☐ Pro	the cause of death?
al Records,		Completed	DIABETES MELLITUS	3				24a. Was an autopsy performer	g/ death?	opsy findings available ompletion of cause of
Vita	ysician: The is certificate hadirector, page	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{N} \) No	Hospital: 1 🛣 Inpatient 2	☐ ER/Outpatient	3CI DOA Other	26. Place of Death	(Check only one)		
Division of	ding Ph I. After th funeral	ation: T	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury Work	4 Nursing Hor	ne 5 Nesidenc 18d. Describe how	e 6 Other (Speci injury occurred	fy)
DIX	To tha Hospital or Attan within 24 hours after deatl To tha Funaral Diractor: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - Al building, etc. (Spe	ecity)	reet, factory, office 28f. Location (Street and City or Town, State)			itate)	
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying Physical Control (Check only one) 2 Medical Exami	sician: To the best of my k ner: On the basis of exami and manner stated.	rnowledge, death ination and/or inve	occurred at the time estigation, in my opi	o, date and place, a nion, death occurre	nd due to the caus od at the time, date	e(s) and manner as s and place, and due t	stated. the cause(s)
i	M Within Some	W	29b. Signature and title of certifier	na	2	29c. License			Date signed (Month,	
	V 5		30. Name and address of person who co	D. 7601 OS	LER DR	,	ON MARY			
: 0	Sta Registra		31. Date filed (Month, Day, Year) MAY 2 6	32. Reg arar's Sig	nature L	/ .		5 500		

			1 - For State Registrar	State of	Maryland	l / Depa <i>Cei</i>	artment of H tificate of L	ealth and M Death	lental Hygi	ene 2004	18397
ž	Physici /Medi		1. Decedent's Name (First, Middle Arthur Norris						Date of Death Month May	Day Year 22 2004	3. Time of Death 10:45 ам
	Examir		4a. Facility Name (If not institution Carroll Hospita		ber)			Location of Death		4c. County of Death)
	Funeral Director		5. Sociat Security Number 213–36–9822		. Age (In yrs. Ia:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 2	Year) 9. Birth	nplace (State or Foreign untry) PA
	inyland show	_	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo			- = w		10d. tnside City Limits 1 ☐ Yes 2 ☐ No
	with the Ma n or 28a-f	Director	MD Ca 10e. Street and Number 1100 Poole Ro	erroll		westn	inster	1157	10	g. Citizen of What Cou USA	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic avant, Ita Modical Experiment could be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Deced	₹No		Was Decedent of Hi f Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
Maryland 21215-0036	d within 72 hou giene. ir than "natura Itre Modical E	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12)	's Education		(Give life. L	dent's Usual Occupa kind of work done of DO NOT use retired	turing most of work)	ing	6b. Kind of Business/li St of MD S Retirenent	upplemental
/land	should be filed and Mental Hyg	To Be C	17. Father's Name (First, Middle, Arthur Norris,		Norris			18. Mother's Name	(First, Middle, M Valiant	-	
	and and is m		19a. Informant's Name/Relations Dave Bowersox/a				g Address (Street a		al Route Number, 'estminst e	City or Town, State, Zier, MD 21	ip Code) 157
altimore,	Pages 1 and 3 nent of Health int: If Item 27 iry or other tr		20a. Method of Disposition 1 Durial 2 □ Cremation 4 □ Donation 5 □ Other (S)		tate cen	netery, cren	sition (Name of natory or other place Int Cemete	9)	/2004	oc. Location - City or T Sandy Mout	
Balti	permit. Pages Department of Important: If It any injury or o		21. Signature of Funeral Service			22	Name and Addres	s of Facility	e and C	hanel. P A	
8760,	Physician /Medical Examiner bhysician and bhysician and strength and	dical Examiner	23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	a	used the death. ch line. PROSC r as a conseque r as a conseque	IERO ince of):	ar the mode of dying	g, such as cardiac of	or respiratory arres	is pare	Approximate Interval Between Onset and Death 7 4 CAPS
P.O. Box 68	The law requires that the death certifics te has been signed by the attending pt age 2 should be detached for use as the	Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2∏Fetald nt at time of dea	leath 3	Ectopic pregnancy Other (specify)			23d. Date of deliv	very Day Year
	quires that in signed by uld be deta	þ	Part II. Other significant conditio	ns contributing to dea	ith but not result	ing in the ur	nderlying cause give	n in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Il Records,		Completed							24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of
Division of Vital	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate ha completely filled in by the funeral director, page	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manger of Death Natural 5 Pendin investig 2 Accident investig 3 Suicide 6 Could	28a. Date of (Month)	Injury 2 Day Year)	R/Outpatien 18b. Time of Injury	28c. Injury Work	or: 4 ☐ Nursing Ho at ?? (es 2 ☐ No	28d. Describe how	ce 6 □Other (Speci	
2	Hospital or A 24 hours after 8 Funeral Dire etely filled in b	al Certi	4 Homicide determ	building g Physician: To the b	g, etc. (<i>Specify</i>) est of my knowl	ledge, death	occurred at the tim	e, date and place,	City or Town, and due to the cau	State) use(s) and manner as s	stated.
	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	Medical	(Check only 2 Medicat one) 29b. Signature and title of certified	and manne	sis of exa <i>m</i> ination stated.	on and/or inv	29c. License			d. Date signed (Month,	
_	10 A.		30. Name and address of person I HOWAS X	GALVN	III (291	Print) STONER	AVENO	e we	STMINSTE	Ry moreday
	Sta Regist		31. Date filed (Month, Day, Year) MAY 2	5 2004 32. Re	pistrar's Signatu	TO 10	berle				

				1 - For State Registrar		State o	of Maryla		artment of rtificate o	Health and More than the Health and More than the Health	lental Hy	giene Reg. No.2	004	18398
		Physici	an	1. Decedent's Name (i	First, Middle,	Last)					2. Date of De	eath Day	Year	3. Time of Death
		/Medi			MANTH		ΓANN		DENBOW		May	27,	2004	4:18P M
	4	Examir	ner	4a. Fecility Name (If no		ī	ımber)		4b. City, Town	n, or Location of Death			nty of Death	
				5. Social Security Num		Center	7 Age (In urs	s. last birthday	If Under 1 Ye	TOWSON ar If Under 24 Hrs.	8. Date of Bir		Baltin	
		Funeral Director		214-11-7		1 □ M 2 K F		26 Yrs.	Months Day		(Month, Da	1977	9. Birthpi Coun	lace (State or Foreign try) 'yland
				Usual Residence of De			60-	. •			9/ 10/	<u> </u>	riar	yrand
		rylan rhow			0b. County		10c. C	ity, Town or L	ocation				10	Od. Inside City Limits
		t 28e-f show	cto	MD.		ford			Jarr	ettsvill	В			1 □ Yes 2 X No
y		vith th	Director	10e. Street and Numb				_	10f. Zip Code				of What Coun	
A'		s 23a	eral		Bald	win Mi	LL KOS edent Ever in		14/ D	21084			ed St	
00		ter dea items	Funeral	11. Marital Status 1 □ Never Married	2 X Marrie	Armed F	orces?	0.3.	If Yes, specify C	of Hispanic Origin? (Sp. Juban, Mexican, Puerto	Rican, etc.))- 14. F	Race - America Black, White, a	
	936	urs aft	þ	3 ☐ Widowed 4 [If Yes, Gi Year or D	VA .		1 ☐ Yes 2 💢 N	No Specify:		Spe	city: Wh	ite
1	5-0036	within 72 hours after death with the Maryland ene. than "natural; or items 23s or 28e-f show ha Medical Examinat must be notified at	Completed	15 (Specify	5. Decedent's	Education grade completed)		16a. Dece	dent's Usual Oct	cupation	ina	16b. Kind of	Business/Ind	
	21	ithin ithin	npie	Elementary/Second		Ť	1-4or 5+)			ne during most of work ired)				
	121	fygier fygier her th	S	1.7. Father's Name (Fit	mt Middle I	()	Bil	ling M			Docto		ffice
10	anc	ntal Hed of	Be	Samu		Jeremi	ioh	Hubb	owd	18. Mother's Name				-1
200	Maryland	should nd Me mark matic	ဂ္	19a. Informant's Name			Lan			Carol eet and Number or Run		uise	vn State Zin	aband
(0	S	s 1 and 2 should be filed within 72 hours after death with I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Experiment must be		Jeffrey			sband	1205	Baldw	in Mill I				11e, Md.
-	ē,	permit. Pages 1 am Department of Heal Importent: if item 2 eny injury or other once.		20a. Method of Dispos	sition		20b.	Place of Disp	osition (Name of matory or other p	place)	Date	20c. Locatio	n · City or To	wn, State
(0	Baltimore	Pages nent of H nnt: if ite	П	1 A Burial 2 □ 0 14 □ Donation 5			State		Cemete		/2004	Madon	na. M	aryland
A	alti	permit. I Departm Importe eny inju		21. Signature of Fune	ral Service Li	celnsele (11 1		2. Name and Ad	dress of Facility Ja	arrett	svill	e. Ma	ryland
E	_	80 E 9 9		P 1/1.	Meso	Wen /	Turk		E.G. K	urts & So	on Fun	eral	Home,	P.A.
5				23a. Part1. Enter the shock, or heart for	disease, or ca ailure. List or	omplications that only one cause on	caused the dea each line.			tying, such as cardiac				Approximate Interval Between
		Physician		Immediate Cause (Fir disease or condition resulting in death)	nal	a	EL	NIV	195	SAVEOY	NA			Onset and Death
		/Medical Examiner		resulting in death)	- 1	Due to	(or as a conse	quence of):	1					0
LU			ia l	Sequentially list condi	tions, ediate	b. — Due to	(or as a conse	quence of):					_	>-78
1-		uted d ansit	Examiner	Sequentially list condi if any, leading to imme cause. Enter Underly Cause (Disease or inju- that initiated events	ing ury								i	
	ó	be executed sician and burial-transit		resulting in death) Las	st	Due to	(or as a conse	quence of):						-
	8760,	ate be executed bhysician and the burial-transii	dicai			d								
	9		Med	IF FEMALE:										
4	Box	eath certifi attending for use as	Physician/Me	23b. Was decedent printhe past 12 mg		1 ☐ Live I	tcome of pregr birth 2 ☐ Fet	tal déath 3[Ectopic pregna				Date of deliver Month	ry Day Year
7	P.O.	he de the a	ysic	1 ☐ Yes 2 X N 9 ☐ Unknown		4⊟Pregi 9□Unkn	nant at time of nown	death 5	Other (specify)					,
		es that the d igned by the be detached	h h	Part II. Other significa	int condition	s contributing to d	leath but not re	sulting in the u	nderlying cause	given in Part I.	23e. Did t	obacco use co	ontribute to the	e cause of death?
AMAN	rds	quires n sign ald be	d by								1 🗆 '	Yes 2 No	3 🗌 Proba	ably 4 DUnknown
کے	000	law requas been 2 should	ompieted								24a. Was		o. Were autop	sy findings available
4	Division of Vital Records,	9 2 9	E O								autor perfo	osy ormed? 2 No	prior to com death? 1 \(\text{Yes} \) :	pletion of cause of
V)	ita	ysicien: Th is certificate director, pag	Be C	25. Was case referred examiner?	I to medical					26. Place of Death				
3	Ž	Physicien: r this certifica ral director, r	၉	1 ☐ Yes 2 No	,			☐ ER/Outpatie	nt 3 DOA	Other: 4 Nursing Ho	me 5 Resid	dence 6 🔀	other (Specify,	Hospico
30	n	ding P	inol		5 Pending		of Injury hth, Day Year)	28b. Time o Injury	V		28d. Describe l	how injury occ	urred	,
ENBOW	isi	death death ctor: / the	icat	2 ☐ Accident 3 ☐ Suicide	investiga 6 ☐ Could no	t be	a of Injuny - At I	home farm et	M 1 eet, factory, office	Yes 2 No	28f Location /	Street and Nu	mhar or Rumi	Route Number.
V	Di√	2 4 5	Certification;	4 ☐ Homicide	determin	ed build	ing, etc. (Spec	ify)	est, factory, offic		City or Tov		noer or marar	Houle Number,
(-)		To the Hospitel of within 24 hours af To the Funerel D completely filled in		29a. Certifier	Certifying	Physician. To the	e best of my kn	iowledge, deal	n occurred at the	ume, date and place,	and due to the	cause(s) and i	manner as sia	119a.
		To the Hos within 24 h To the Fur completely	Medical	(Check only § [☐ Medical Ex	kaminer: On the b and man	asis of examin mer stated.	ation and/or in	vestigation, in m	y opinion, death occurr	ed at the time,	date and place	e, and due to	the cause(s)
		with To t	Σ	29b. Signature and titl	e of certifier	1	10		29c. Lice	ense number		29d. Date sign	ned (Month, D	Day, Year)
	•			191	Hel	rong 1	W) · une	1)2	7907		MAY	270	×00 ×
		5		30. Name and address	of person wh			m 23a) (Турв, 670 /	Print)	isolos arle, G.	Bald-	md	2/2	0 5
		Sta	ite	31. Date filed (Month,	Day, Year)		Regitrar's Sign		,					
		Regist			JUN :	1 2004	Barre	63	forthe p					

_			1 - State of Mary		artment of H			iene eg. No. 200	4 183 99
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Edith Agnes Day				2. Date of Deat May 30	, Day 2004 Yee	3. Time of Death 1:15 рм
	Examir	ner	43. Facility Name (If not institution, give street and number) 4300 Doncaster Drive 5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	4b. City, Town, or Indian If Under 1 Year			4c. County of De	Les
	Funeral Director		216-30-4911 1 M 2 KF 88 Usual Residence of Decedent	Yrs.	Months Days	Hours Min.	Dec. 3	0,1915 v	irthplace (State or Foreign Sountry) Vashington [
	he Marylar 28a-f show	ector	Maryland Charles	c. City, Town or Lo	Head				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	th with t	Funeral Director	4300 Doncaster Drive		10f. Zip Code 2064	10	10	Dg. Citizen of What C U.S.A.	•
900	2 should be filed within 72 hours after death with the Maryland and Menial Hygiene. is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Modeal Examinat must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Nover Married 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 ☐ No		pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh Specify: Wh	ite, etc.
Maryland 21215-0036	ifiled within 72 h Hygiene, other than "netuent, Ibe Walled	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4or 5+)		dent's Usual Occupa kind of work done d DO NDT use retired) emaker	tion uring most of wor	1	16b. Kind of Busines Her Home	,
and	ild be file lental Hy rked oth	To Be (17. Father's Name (First, Middle, Last) Joseph Haislipp			18. Mother's Nan	ne (First, Middle, M Mae G	daiden Sumame) ibson	
Mary	s 1 and 2 should if Health and Menitam 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) George P. Day, Jr. Son			nd Number or Ru	ral Route Number,	City or Town, State,	Zip Code) Md. 20640
Baltimore,	Pages 1 and 3 nent of Health int: If itam 27 iry or othar tri		20a. Method of Disposition 1	b. Place of Dispos cemetery, cren	sition (Name of natory or other place)	Date 2	Oc. Location - City o	r Town, State
Baltir	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service License	22	Heaven Name and Address	of Facility		Silver S P.A. dian Hea	
8/60,	the death certificate be executed Where attending physician and some as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complications that caused the shock, or heart ailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conduction of the cause). Due to (or as a conduction of the cause).	death. Do not enter the sequence of): Sequence of): Sequence of): Sequence of):	or the mode of dying.	such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
O. Box 6	ie death certif the attending hed for use a:	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 20 No 9 □ Unknown 23c. If yes, outcome of prediction in the past 12 months? 1 □ Live birth 2 □ If the pregnant at time 9 □ Unknown	Fetal déath 3 □	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
oras, r.	w requires that the been signed by should be detack	by	Part II. Dther significant conditions contributing to death but not	resulting in the un	derlying cause given	in Part I.	23e. Did toba	. /	the cause of death?
ပ္	S 5 2	e Completed	25. Was case referred to medical					prior to	utopsy findings available completion of cause of
IVISION OF VI	Phy	Certification; To B	examiner? 1	2 ER/Outpatient 28b. Time of Injury	3 DOA Other: 28c. Injury a Work?	4 ☐ Nursing Ho	h (Check only one) me 5 Resident 28d. Describe how	ce 6 Other (Spe	city)
2	To the Hospitel or Attanding within 24 hours after death To tha Funaral Diractor: After completely filled in by the fune		4 Homicide determined 286. Place of injury - A building, etc. (Sp	ecify)			City or Town,		
	of the Hosp thin 24 ho tha Funa mpletely fi	Medical	29a. Certifier (Check only one) 2 Medicel Exeminer: On the basis of exam and manner stated.	knowledge, death nination and/or inve	estigation, in my opin	ion, death occur	ed at the time, date	e and place, and due	to the cause(s)
	T wit		29b. Signature and title of certifier 30. Name and address of person who completed cause of death (tram 23a) (Tuna B	29c. License n	201	25 290	I. Date signed (Month	h, Day, Year)
1	B4		31. Date filed (Month, Day, Year) 32. Pointer's Si	12 Hon	2 MAD	MA	roon	r, md	20203
	Stat Registra		JUN 0 2 2004		المان				

			1 - For State Registrar		epartment of Health and Certificate of Death		ene . No. 2004	18400
п	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
1	/Medi		Lloyd A. Do				2004	0300 M
1	Examir	ner	4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Dec	_	4c. County of Death	
			Charlotte Hall 5. Social Security Number 6. Sex		Charlotte Hal		St. Marys	
ľ	Funeral Director		212-12-0800	M 2□F 86 Yr	Months Days Hours Mil			ice (State or Foreign y) yland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location		100	d. Inside City Limits
	Mary -1 sh	Ď,	Marriland Anno Am	undal Diagram				1 TyYes 2 □ No
	r 28a	Directo	Maryland Anne Art 10e. Street and Number	undel Edgewa	10f. Zip Code	10g	. Citizen of What Countr	y?
	th wit		408 Mill Swamp	Road	21037		USA	
	ems ems	Funerai			13. Was Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - America	
36	or the	F	1 Never Married Married	117 Yes 2 □ No	1 ☐ Yes 2 □ No Specify:	sito riloati, etc.)	Black, White, et	
Ö	72 hours after death with the Maryland natural', or items 23a or 28a-1 show disal Exeminat must be notified at	d by	3 Widowed 4 Divorced	Year or Dates: W. W. TT			Specify: Blac	
21215-0036	n 72	Completed	15. Decedent's Educ (Specify only highest grade	completed) (0	ecedent's Usual Occupation Give kind of work done during most of w ife. DO NOT use retired)	orking 16	b. Kind of Business/Indu	stry
12	within iene. then	шc	Elementary/Secondary (0-12)	Colfege (1-4or 5+)	· · · · · · · · · · · · · · · · · · ·	_	2	
	illed Hygir other	Be C	17. Father's Name (First, Middle, Last)		larpenter 18. Mother's Na	ame (First, Middle, Ma	ederal Gor den Sumame)	vernment
lar	should be nd Mental marked c	To B	Anthony Downs		Mary	Wallace		
Maryland	2 should he ma le ma suma		19a. Informant's Name/Relationship (Type	oe, Print) 19b. N	Maifing Address (Street and Number or F		ity or Town, State, Zip C	code)
	A # 17 #		Pearl Downs (Wife	fe) 408	B Mill Swamp Rd.	Edgewate	er, Md. 21	1037
ore	of High	- 5	20a. Method of Disposition 1. Ø Burial 2 ☐ Cremation 3 ☐ Re		isposition (Name of orematory or other place)	Date 200	c. Location - City or Tow	n, State
Ē	Pages Iment of I Iant: If its jury or o		*4 □ Donation 5 □ Other (Specify)	Cemete	The state of the s	24/04 0	vensville.	MA.
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other once.		21. Signature of Funeral Service License	e M00483	Wm. Reese & Son	A SERVICE SERVICE		
- 6	100		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the death. Do not	821 West St. An	napolis, ac or respiratory arrest,	A	oproximate
şsi .	Physician	0	Immediate Cause (Final disease or condition	Adams of each mile.	cci anala at	Show	0 6	nterval Between Onset and Death
35.	/Medical		resulting in death)	Due to (or as a consequence of)	vcinoma of	370/11	acre	
161	Examiner		Sequentially list conditions, b.					
	sit ad	Examiner	If any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):				
	and and -tran	каш	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequence of):				
760,	ate be executed hysician and the burial-transit	ical E		Due to (or as a consequence or).				
687	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dic	d.					-
Вох (uires that the death certifica signed by the attending pt d be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy			23d. Date of delivery	
ă	death a atte	cia	in the past 12 months?	4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Da	ay Year
0	t the by the ache	hys	9 Unknown	9□ Unknown				
S,	as tha gned se del	by P	Part II. Other significant conditions cont	tributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobac	co use contribute to the	cause of death?
Records,	w require been si should b	ed	Chronic Ope	structure pul	Monary Disea	J □ Yes	2 □ No 3 Probab	ly 4 Unknown
ecc	e law n has be je 2 sh	Completed	Diabetes	Mellitus		24a. Was an	24b. Were autopsy	findings available
<u> </u>		Com	Alzheimen	5 Disease	9	autopsy performed	death?	letion of cause of
Vital	ysician: The is certificate hadirector, page	Be (25. Was case referred to medical examiner?			ath (Check only one)		
0	Physi this c	은	1 ☐ Yes 2 No	ospital: 1 Inpatient 2 ER/Outpa		Home 5 Residence		
u C	ding P h. After t funera	ion:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Tim	ry Work?	28d. Describe how in	njury occurred	
Sic	Attendi death. ctor: A y the fu	icat	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be	29a Place of laive. At home form	M 1 Yes 2 No	204		
Division	tal or A rs after al Direct ed in by	Certification:	4 Homicide determined	28e. Pface of Injury - At home, farm, building, etc. (Specify)	Street, factory, office	City or Town, S.	and Number or Rural R ate)	oute Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director, to	Medical (29a. Certifier 12 Certifying Physic (Check only one) 2 Medical Examina	cian: To the best of my knowledge, der: On the basis of examination and/o and manner stated.	eath occurred at the time, date and plac r investigation, in my opinion, death occ	e, and due to the cause urred at the time, date	e(s) and manner as state and place, and due to th	ed. e cause(s)
	To the Mithin Fo the	Me	29b. Signature and title of certifier	- manual states.	29c. License number	29d.	Date signed (Month, Da)	v, Year)
			· / // / 0		1700520	97 1	15/20/-	VKK
			30. Name and address of person who con	ppleted cause of death (Item 23a) (Ty	pe, Print)	/ / /	3/00/0	TOU T
_			100 Hospital Rd	I Prince Fr	ederrik, mD	2678	Janelleis	ellimo
₩.	Sta Registr	-	31. Date filed (Month, Day, Year) MAY 2 6 20	32. Registrar's Signature	Small !	2		

ORIGINAL

			1- State of Maryland / Department of Health and Months Registrar State of Maryland / Department of Health and Months Registrar	ental Hygi	iene 19. No. 2004	18401
	Physici /Medio Examir	al.		2. Date of Death Month May	Day Year 23 2004 4c. County of Death	3. Time of Death 2:50 P
	Funeral Director		1 M 2 F P Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day,		del place (State or Foreign intry) vland
	the Maryland 28a-f show colling at	Director	Maryland Anne Arundel Annapolis			10d. Inside City Limits
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28a-f show any injury or other treumatic event, The Medical Evertil or must be multified at once.	by Funeral	35 Milkshake Lane 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation	cify Yes or No- Rican, etc.)	g. Citizen of What Cou Inited Stat 14. Race - Ameri Black, White, Specify: Whi 6b. Kind of Business/ir	es can Indian, etc.
Maryland 21215-0036	filed within 7 Hygiene. rther then "r ont, the Med	e Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1 College (1-4or 5+) Homemaker 18. Mother's Name	g (Own Home	
larylan	should be and Mental is marked o	To Be	John C. Shipperd Louise Jan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural	ne Taylo	r	c Code)
Baltimore, M	Pages 1 and 2 ent of Health nt: If item 27 i		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State cemetery, crematory or other place)	ate 2	Oc. Location - City or To	own, State
■ Balti	permit. Departm Importe any inju		21. Signature) of Funeral Service Licensea 22. Name and Address of Facility 147 Duke of Glouces	ohn M. I ster St.	Annapoli	ral Home, In
	Physician /Medical Examiner	Je.	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):	respiratory arres	st,	Approximate Interval Between Onserand Death
68760,	tificate be executed ig physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):			
P.O. Box	death cer e attendir ed for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delive Month	ery Day Year
Ś	The law requires that the tee has been signed by the bage 2 should be detached.	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	_	cco use contribute to the	ne cause of death?
Vital Record		e Completed	25. Was case referred to medical 26 Place of Death (prior to con death?	psy findings available inpletion of cause of 2 No
Division of Vi	ding Phys	Certification; To B	examiner? 1		ce 6 Other (Specify injury occurred	0
DIVI	Hospitel or Attenc 24 hours after death Funerel Director: tely filled in by the		29a. Certifier **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	City or Town,	se(s) and manner as et	atod
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	Medical	(check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and titlerof certifier 29c. License number	at the time, date	and place, and due to and place, and due to	the cause(s) Day, Year)
4	Sta Registra		31. Date filed (Month, Day) Year) MAY 2 5 2004 MAY 2 5 2004 MAY 2 5 2004 MAY 2 5 2004	(M)	21619	

State of Maryland / Department of Health and Mental Hygiene 2001 18402 1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Year Pauline Alice Dove A^{M} June 2004 0547 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital Elkton Ceci If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG 7, 1917 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Vest Virginia 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 ☐ M 2 🖾 F Yrs. AÙG Director 236-22-7029 West Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "neturel", or items 23a or 28a-1 show amy injury or other treumatic event, the Medical Exercises must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Directo Cecil Maryland Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 126 Elk Chase United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: 3 ☑ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Her Own Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nathan Lee Leslie Viola Alice Rollyson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela S. Philhower/Daughter 39 Pinder Avenue, Elkton, Maryland 21921 20b. Place of Disposition (Name of June 7, 20a. Method of Disposition 20c. Location - City or Town, State R.A. Ferris & Co. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State West Chester, `4 ☐ Donation 5 ☐ Other (Specify) 2004 Inc. Pennsylvania 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Fineral Service Licen A 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Lause (Final disease or condition resulting in death) GASTRIC Enysician PERFORATED 4 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, that is a list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examine signed by the attending physician and the detached for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: Division of Vital Records, P.O. Box 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CANCEK METASTATIC 1 Yes 2 No 3 Probably 4 donknown should I ANEMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has t irector, page 2 s autopsy performed 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 ☐ Yes 2 ☐ No this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral i 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital c within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D00511 JUNE 5, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GUP ,#320, WILMINGTON DE 19801 110 STREET 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2001 18403 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2118 P M June 4 2004 Victor L. Doyle /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Elkton Union Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1⊠M 2□F Yrs. Director 221-07-8811 Delaware Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "naturel", or Items 23s or 28s-1 show ury or other traumatic svent, the Medical Examinat must be notified at 1 ☐ Yes 2 ☑ No Directo Delaware New Castle Newark 10f Zip Code 10g. Citizen of What Country? 10e, Street and Number 1736 Old Baltimore Pike 19702 United States 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🌠 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: 3 \ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Building Maintenance Property Management 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jenney Heatherton George W. Doyle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1189 Federal Farm Road, Montross, Virginia 22520 Veda L. Bottomley/Daughter 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State June 9, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If sny injury or snot * 4 ☐ Donation 5 ☐ Other (Specify) Mt. Salem Cemetery 2004 Wilmington, Delaware 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licenses 103 W. Stockton Street, Elkton, Maryland 21921 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner the death certificate be executed physician and the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medicai as the attending (IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. been signed by the s should be detached Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 2 X No 1 Yes 3 Probably 4 Unknown 1 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has 2 X No certificate 1 ☐ Yes of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 Outpatient 3 DOA completely filled in by the funeral dir this 28c. injury at Work? 27 Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Matural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide To the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Exam 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) limot 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) May 26 2004 **Physician** Fried 1920 Martha Μ. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Solomons

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Month, Day Year)

March 18 1927 11629 Asbury Circle Calvert Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 □ F 301 22 0087 77 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits rthan "neturel", or Items 23a or 28a-f show I're Mudical Examinational be notified at 1 ☐ Yes 2 ☐ No Director Maryland Calvert Solamons 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11629 Asbury Circle 20688 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 Widowed 4 Divorced Be Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 5+ Human Resources Retail Sales or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 Is marked oth any lijury or other traumatic event 2008. Thomas Rucker Ruth Youm 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jill Fried Broderick — dauchter 17723 Garrett Dr. Gaithersburg Maryland 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) May 27
Metropolitan Funeral Service Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Alexandria Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home Raws 4405 Brownes Is. Rd. Fort Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) acute myocardial infarction **Physician** 1 hour /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa Causa or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Completed by Physician/Medical as the use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death signed by the at d be detached fo 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 2 No 1 ☐ Yes Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Yes 2 ☑ No 4 Nursing Home 5 Mesidence 6 □Other (Specify, ို 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; After or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Diractor: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 T Homicide To the Hospital completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D46314 May 27, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Paul V. Pomilla, MD Prince Frederick Maryland 20678 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 8 2004 Registrar

A		1 - State RegistraAMEND ITEM #1	State of Maryland						2001	4 18605
Physici	an '	1. Decedent's Name (First, Middle, Last)	AS LEW THE GO.	oz wemoje	CHOUNT L	Jean	2. Date of Dea Month	eg. No. th Day	Year	3. Time of Death
/Medic Examir	cal	Mary Helen Fou- 4a. Facility Name (If not institution, give st		4b. (City, Town, or	Location of Death	June 6	71	004 County of Deat	2:40 A M
Funeral		7730 Peters Ro 5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday) If U	lamsto	Wn If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	ederic	ck thplace (State or Foreign buntry)
Director		214-32-4850 1 Usual Residence of Decedent	M 2X F 70	Yrs.		110013	Oct. 26	, 19	33 Mai	ryland
Marylan -1 ahow Ilex at	tor	10a. State 10b. County Maryland Frederi		Town or Location						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the	Dire	10e. Street and Number		10	Zip Code				en of What Co	ountry?
be filed within 72 hours after death with the Maryland that Hygiene. Ital Hygiene. Individual instural, or Itama 23a or 28a-f ahow avent. If a Medical Examinar must be notified at	by Funeral	7730 Peters Roa 11. Marital Status 1 Never Married 2 Married 3 Nidowed 4 Divorced	Q. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was D	21710 ecedent of His specify Cubar es 2 No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		4. Race - Ame Black, White Specify:	
INICITY OF THE LEGIOUS OF THE LEGIOUS OF THE STREET OF THE	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	16a. Decedent's (Give kind o life. DO No	Usual Occupa of work done do Tuse retired)	uring most of wor	king	16b. Kin	What of Business	nite /Industry
filed wil Hygien Other th		17. Father's Name (First, Middle, Last)		self		18. Mother's Nan	ne (First, Middle,		emake:	<u> </u>
Mental Mental rked o	To Be	Elmer Sylvester	Wiles			Mary Na	aomi Br	ande	enburg	3
		19a Informant's Name/Relationship (7/0 ASHLEY F. FOUCHE/F. Ashley F. Wiles 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	, husband , husband 20b. Plac cent	7730 F ce of Disposition netery, crematory	eters (Name of or other place	Road,	Adamst Date	OWIL 20c. Loc	MD ation - City or	21710 Town, State
DAILLIMOTE, Definit. Pages 1 ar Department of Hea mportant: If Itam: any injury or other page.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	Mt.				/9/2004			ek, MD neral Home
Dep and and and and and and and and and and		23a. Part1. Enter the disease, or compile shock, or heart failure. List only one	ger M0099	19 1106	East	Church	Street	, H'1	rederi	ick, MD 217
payon to the property of the physician and bhysician and street by the buriat-transit units of the print of t	Ilcal Examiner	Immediate Cause (Final disease or condition resulting in death)	Respiratory Fa	nce of):						Onset and Death 24 hours
The Collus, F.O. BOX 00 The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as it	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	ic. If yes, outcome of pregnanc 1 Live birth 2 Fetal d 4 Pregnant at time of dea 9 Unknown	eath 3 Ecto	pic pregnancy or (specify)			2:	3d. Date of de Month	iivery Day Year
uires that signed b		Part II. Other significant conditions conf	inbuting to death but not result	ing in the underly	ing cause give	en in Part I.	23e. Did to			o the cause of death?
	Completed							sy med? 2 No		utopsy findings available completion of cause of
OI VICAL Physician: This certifica	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No	ospital: 1 ☐ Inpatient 2 ☐ EF	P/Outpatient 3[DOA Othe		ath <i>(Check only o</i>		☐Other (Spe	ocify)
5 £ 70 C	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		8b. Time of Injury	28c. Injury Work	rat ⟨? Yes 2 □ No	28d. Describe h	ow injury	occurred	
2	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)				City or Tow	n, State)		ural Route Number,
Lotha Hospital within 24 hours a Tothe Funeral C	Medical	29a. Certifier 1 \(\sum_{\text{Certifying Phys}}\) (Check only one) 2 \(\sum_{\text{Medical Examin}}\)	ician: To the best of my knowl er: On the basis of examinatio and manner stated.	edge, death occi in and/or investig	urred at the tim ation, in my op	ne, date and place pinion, death occu	e, and due to the during at the time, of	ause(s) a late and	and manner a place, and du	s stated, e to the cause(s)
To the To the compl	Me	29b. Signature and title of certifier			29c. License		1		•	th, Day, Year)
-1		30. Name and address of person who con	moletad cause of dooth (from 5	(Tuna Brich)	D4186	ь		une	7, 200	4
		K. Hudhud, 46-B Th	nomas Johnson	Drive, H	rederi	ck, MD	21702			
St Regist	ate rar	31. Date liled (Month, Day, Year)	32. Registrar's Signatu			rach s				

			State of Maryland / Department of Health and 1 - State of Maryland / Department of Health and Certificate of Death		200	1 10100
	ó		Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Dea		3. Time of Death
	Physici		DOMI RODELC LALICIL	June	4, 2004 Year	1516 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea		4c. County of Dea	
Ď			SACRED HEART HOSPITAL CUMBERLAI		ALLEG	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr 219-14-7007 1 Min Days Hours Mir Pyrs.	n (Month Day	2 102/	rthplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	bune i	2,1924	MD
	rylanc how		10a. State 10b. County 10c. City, Town or Location LaVale			10d. Inside City Limits
	Ba-f s	cto	Allegally Davale			YOYes 2 No
	filed within 72 hours after death with the Maryland Hygiene. kther then "naturel", or Items 23a or 28e-f show ant, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 1225 Braddock Road 21502		10g. Citizen of What C USA	ountry?
	ems Serma	iner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Armed Forces? 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	- 14. Race - Am Black, Whi	
36	or It	by Fu	1 □ Never Married 2 Narried 1 ♥ Yes 2 □ No 1 □ Yes 2 No 1 □	,	Specify: W	
21215-0036	ture!				16b. Kind of Business	
75	nin 72 n "na Medis	Completed	(Specify only highest grade completed) (Give kind of work done during most of we life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	rorking		,
21	d with giene er the	Com	12 3 Supervisor		Governme	nt
and	d be file ental Hy ced oth c event	To Be (o 17. Father's Name (First, Middle, Last) P Edward J Farrell Marie	ame (First, Middle, A. Birn	Maiden Sumame) ningham F	arrell
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other then "naturel; or Items 23a or 28a-f show any injury or other treumetic event, the Medical Examiner must be notified at once.	F	19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F		-	
re, l	is 1 and of Health item 27 other t		Mary Farrell, Spouse 1225 Braddock Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
<u>E</u>	Page ment c ent: If ury or	1			Mount Sa	
Baltimore,	permit. Depart Import any inj		21. Hours of Funeral Service Licensee 22. Name and Address of Facility Ha 1302 National F	afer Fun	neral Ser	vice, P.A.
			23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	ac or respiratory ar	rest,	Approximate Interval Between
Ł	Physician		Immediate Cause (Final disease or condition Ventucular Fibr. 12 tion			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):			10 100
		-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			60 mins
5.	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) last			>10 years
7	exection and and rial-tra		Due to (or as a consequence of).			,
3760	death certificate be executed e attending physician and ad for use as the burial-transit	Physician/Medical				
39 x	ertifica ling ph e as t	Med	IF FEMALE:			
Box 6	that the death certific ed by the attending p detached for use as	ian	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of de Month	livery Day Year
o.	the de y the iched	ysic	1 Yes 2 No 9 Unknown			
S, P.	se ug	by	Fair II. Other significant conditions continuously to death out not resulting in the underlying cause given in rate.		obacco use contribute t res 2 ☐ No 3 ☐ P	o the cause of death?
0.0	w require been si should l	eted	Hyper tension Distry			
Records,	ne law has b ge 2 s	Completed			sy prior to death?	utopsy findings available completion of cause of
	icien: Th certificate rector, pag	e Co		1 ☐ Yes eath (Check only or		3 2 □ No
>	ysicie s cert direct	To B	examiner?		ence 6 Other (Spe	ecify)
on of Vital	Attending Physicien: or death. ector: After this certifice by the funeral director.				ow injury occurred	,
oj.	ttendir death. ctor: Af y the fu	catic	2 Accident investigation 3 Suicide 6 Could not be			
Divisi	l or Attendater deatl Director: I in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	itreet and Number or R n, State)	ural Route Number,
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical C				
	ro the	Mec	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mon	th, Day, Year)
	2 - 0		> (ses A. Zudan ms Doo428.	40	June 4,	2004
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RESO A SRICKSON MD, 900 SETON DRIVE, CMY		s dm c	1502
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	- 11091511		OUNT TOUT TOURS IN THE SECOND			

				partment of Health and Mental Hi ertificate of Death	ygiene 2004 18407
ì	Physici /Media		Decedent's Name (First, Middle, Last) DOLLY DIANA GILMORE	2. Date of E Month MAY 2	Day Year
	Examir		4a. Facility Name (If not institution, give street and number) 322 MARY AVE.	4b. City, Town, or Location of Death WESTMINSTER	4c. County of Death CARROLL
1) A	Funeral Director		5. Social Security Number $ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	ff Under 1 Year If Under 24 Hrs. 8. Date of B Months Days Hours Min. 3 / 1 2	9. Birthplace (State or Foreign Country) / 1 9 4 3 MARYLAND
	e Maryland 3a-f show	Director	10a. State 10b. County 10c. City, Town or L WESTMI		10d. fnside City Limits 1 ☐ Yes 2 🔏 No
	ath with th		10e. Street and Number 322 MARY AVE.	101. Zip Code 21157	10g. Citizen of What Country? USA
15-0036	be filed within 72 hours after death with the Maryland nat Hygiene. Id other than "natural", or Itams 23a or 28a-f show event. Inst Medical Evarifies must be routified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes Z ☑ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:	14. Race - American Indian, Black, White, etc. Specify: WHITE
N	d within 72 h jiene. r than "netu ine Medical	Completed	(Specify only highest grade completed) (Giver Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) ICE OFFICER	16b. Kind of Business/Industry LAW ENFORCEMENT
Maryland 21	ed in p	To Be C	17. Father's Name (First, Middle, Last) ALEXANDER BA	18. Mother's Name (First, Middle SS LILLIAN	e, Maiden Sumame) SKLAR
e, Mar	s 1 and 2 should if Health and Men item 27 is marks other traumatic		KENNETH J. WOLLE -HUSBAND 322	ing Address (Street and Number or Rural Route Num MARY AVE., WESTMINS	ber, City or Town, State, Zip Code) TER, MD. 21157
Baltimore,	t. Page rtment o rtant: If njury or	1	4 □ Donation 5 □ Other (Specify) MEADOW B	matory or other place) RANCH CEM. 5/26/04	20c. Location - City or Town, State WESTMINSTER, MD.
g	Dermi Depa Impo any ir		2	2. Name and Address of FacilityFLETCHER 54 E. MAIN ST., WESTM	INSTER, MD. 21157
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart-failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	adyverenom	Onset and Death
nh.	1.2	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	intinoun	
8/60,	ate be hysicii the bu	dicai	resulting in death) Last Due to (or as a consequence of): d.		
O. BOX 6	death certifi e attending p d for use as	hysician/Me		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
ords, r	w requires that the been signed by th should be detache		Part II. Other significant conditions contributing to death but not resulting in the c		tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
	The law ate has b page 2 st	Comple		24a. Was auto perfo 1 □ Yes	s an 24b. Were autopsy findings available prior to completion of cause of death? 2 N 1 Yes 2 No
ı vıtalı	Z d is	To Be	25. Was case referred to medical examiner? 1 Yes	26. Place of Death (Check only ont 3 □ DOA Cther: 4 □ Nursing Home 5 🔀 Resi	
o uoisioi	After After	Certification:	27. Manner of Death 1	M 28c. Injury at Work? M 1 Yes 2 No	how injury occurred
2	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune tune.		4 Homicide determined 288. Place of injury - At nome, farm, st building, etc. (Specify)	City or To	(Street and Number or Rural Route Number, wn, State)
	To the Hospitel or within 24 hours after to the Funerel Dir completely filled in	ledicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, and due to the vestigation, in my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	MZ-	Σ	29b. Signature and title of certifier	29c. License number D25443	29d. Date signed (Month, Day, Year)
	. (6		30. Name and address of person who completed cause of death (Item 23a) (Type, JOHN W. MIDDLETON, MD 688 POOT		MD. 21157
100	Stat Registra		31. Date filed (Month, Day, Year) MAY 2 6 2004 Series 15		

- P	hysiai		For AMEND#23a 6/1/0 State per Phy. AAOO 1. Decedent's Name (First, Middle,		omh .	Cei	tificate of	Death	2. Date of D			3. Time of Death
	hysicia /Medic xamin	al	Mabel L. Gal 4a. Facility Name (If not institution,	give street and number	ər)	_	4b. City, Town, o		May	22, 4c.	2004 County of Death	5:30p M
Dire	neral ector		126 Shore Roa 5. Social Security Number 414-24-3254 Usual Residence of Decedent		Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	Arno If Under 24 Hi Hours Mil	s. 8. Date of B	lirth Day, Year)	Anne Ar 9. Birth Coul	rundel place (State or Foreign ntry) TN
e Maryland	tiffed at	ctor	10a. State 10b. County MD Anne A	rundel		, Town or Lo	cation					1 ☐ Yes 2 ☑No
e 234 or 21	munites no	Funeral Director	126 Shore Road	10 W- D- 1			10f. Zip Code 210				izen of What Coul	
5-0036 72 hours after death with the Maryland	ration Continue to notified at	ρ	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Deceder Armed Force d 1 Tyes 2 filf Yes, Give Year or Date	s? ∑No	1	Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 🔀 No		Specify Yes or N irto Rican, etc.)	10-	14. Race - Americ Black, White, Specify: Whit	etc.
within Bre.	the Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4d	or 5+)	(Give life. l	lent's Usual Occup kind of work done of DO NOT use retired Custodian	during most of w 1)	orking	Anne	and of Business/In Arundel	County
Maryland 2 Id 2 should be filed Ith and Mental Hygis 77 amrked other	- A	To Be C	17. Father's Name (First, Middle, La James Taylor	ast)				18. Mother's Na	ame (First, Middles Sharp	e, Maiden		
C = "	r traum		Joyce Nicolai/			15	g Address (Street : 52 Cresst	on Road	Arnol		r Town, State, Zip 21012	Code)
Baltimore, permit. Pages 1 a Department of Hear	injury or othe		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	city)	te Gle	en Hav	sition (Name of natory or other place of Men.	Park 20	ay 26,		cation - City or To en Burni	
Balti permit. Departm	any ir		21. Shaature of Fineral Services In Part 1. Enter the disease, or of	X) DSSC	med the death		Name and Address Pranco & S Gov. R				Park Fu Park, M	neral Home D 21146
Physi /Med	dical	(sho , or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a.	line.	050	eusy		vdava		illera	Approximate Interval Between Onset and Death
68 / 60, illicate be executed XX or physician and	ne burial-transit	fical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Hyperch	olestero	olemia	Jepen Jepen	dem	<u>.</u>			
death cert eattendin	detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal of at time of dea	death 3	Ectopic pregnancy Other (specify)			2	23d. Date of delive Month	ry Day Year
Ords requires een sigr	peq	ģ	Part II. Other significant condition	s contributing to death	but not result	ting in the un	derlying cause give	en in Part I.		tobacco u	/	e cause of death?
	96.2	e Completed	25. Was case referred to medical						1 ☐ Yes	ormed? 2 ☑ No	24b. Were autop prior to con death? 1 \(\subseteq Yes	osy findings available inpletion of cause of 2 No
ISION OF ttending Phys death. ctor: After this	funeral di	6 B	examiner? 1 Yes 2 10 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could no	28a. Date of In (Month, Date)	Day Year)	28b. Time of Injury	28c. Injury Work	4 Nursing	28d. Describe	idence 6 how injury		
UIV Hospital or A 24 hours after Funeral Dire	completely filled in by the		4 Homicide determine 29a. Certifier 1 Certifying (Check only 2 Medical Ex	building,	etc. (Specify)	ledge death	occurred at the tim	e, date and plac	City or To	wn, State)	and manner as st	and a
To the Hospital Within 24 hours a To the Funeral E	complete		29b. Signature and title of certifier	aminer: On the basis and manner:	stated.		29c. License		urred at the time,		place, and due to	
	Stat		30. Name and addre of person what on a Pluci Antonia Pluci 31. Date filed (Month, Day, Year)	5 1509	R:+d ktrar's Signatu	hie H		uold M	lal. 2101			

ORIGINAL

			1 - For State Registrar	State of Marylan	nd / Depa <i>Cer</i>	rtment of H	lealth and Death		giene 2 () (04 1840
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last Arres 6 Arres 6 Arres 6 Arres 6 Arres 6 Arres 6 Arres 7 Arres 7	GROSS	blac	4b. City, Town, or	Location of Dea	2. Date of Dea Month	Day Y	aar 1448 M
	Funeral Director		Usual Residence of Decedent	MM 2□F 61	Yrs.	If Under 1 Year Months Days	Hours Min			Birthplace (State or Foreign Country) MD
	h the Marylar r 28a-f ehow inctified at	irector	10a. State 10b. County Anne Art		y, Town or Loc		na Park	1	0g. Citizen of Wha	10d. Inside City Limits 1 Yes 2 No
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "naturel', or Itams 23e or 28e-f show styl injury or other traumatic event, the Medical Evanting must be neithed at ance.	by Funeral Director	320 Marlin Spike 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Drive 12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	tf		1146 spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - /	ISA American Indian, White, etc. White
Maryland 21215-0036	filed within 72 hou Hygiene. other then "naturel ent, tre Medical E.	Completed t	15. Decedent's Ed (Specify only highest gran Elementary/Secondary (0-12)	lucation	(Give k life. D	ent's Usual Occupa ind of work done d O NOT use retired, ior Budge	uring most of wo	rking	16b. Kind of Busin	ess/Industry f Maryland
ıryland	2 should be fited within and Mental Hygiene. Is marked other then aumatic event, Ine Ma	To Be	17. Father's Name (First, Middle, Last) John Gross 19a. Informant's Name/Relationship (7)	voe Print)	19h Mading	Address (Street a	Estell	me (First, Middle, I e Mytka	Maiden Sumame) , City or Town, Stal	
altimore, Ma	Pages 1 and 2 s nent of Health ar int: if Item 27 is iry or other trau		Barbara Gross/Wi 20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □	fe 20b. P	320 lace of Disposi emetery, crema	Marlin S ition (Name of atory or other place	Spike Dr	ive, Seve	erna Park 20c. Location - City	, MD 21146 or Town, State
Baltin	permit. Pag Department Important: I any injury o once.		*4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service License		Bai	Slaus Cen Name and Address rranco & 5 Gov. Ri	Sons, P	.A. Sever	Dundalk,	MD Funeral Home MD 21146
8/60,	Physician bhysician and bhysician and bhysician and physician street is the printer. It are the printer in the printer in the printer in the physician and p	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indicate cause.	b. Due to (or as a consequence. Due to (or as a consequence. Due to (or as a consequence.	Do not enter BC LEM Jence of):	the mode of dying Hic	, such as cardia	or respiratory arre	sst,	Approximate Interval Between
O. Box 6	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 □E	ctopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
cords, P	requires t	þ	Part II. Other significant conditions co	ntributing to death but not resu	Iting in the und	erlying cause giver	n in Part I.			e to the cause of death? Probably 4 Unknown
He He	The la ate has page 2	e Completed	25. Was case referred to medical				00 70	24a. Was an autopsy perform	prior 1 death	autopsy findings available o completion of cause of ? es 2 \(\sum \text{No}\)
10 1	ng Phys fter this ineral di	ertification: To B	examiner?	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	3 DOA Other 28c. Injury a Work? M 1 Ye	4 Nursing H	th (Check only one ome 5 Resider 28d. Describe how	nce 6 Other (S	oecify)
2	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	OL	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)			date and place	City or Town,	State)	Rural Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medicai	(Check only 2 Medical Exami	ner: On the basis of examination and manner stated.	on and/or inves	stigation, in my opin	nion, death occur	red at the time, dat	te and place, and d	ue to the cause(s)
			30. Name and address of person who co	- Continues		(a) 9.5	- An	erien	0,4.	21035
	Stat	~ 1	31. Date filed (Month, Day, Year)	32. Redistrar's Signatu	IT A	and a	1 10		<u> </u>	71001

			For		of Marylan						•		e oo		1.51.
			1 - State Registrar			Ce	rtificat	e of l	Death			Reg. N	<u>.</u> 20	Ul	1841
	Physici	an	Decedent's Name (First, Middle,	Last)							2. Date of De Month		ay Y	ear	3. Time of Death
	/Medic	al	James L. Goossen 4a. Facility Name (If not institution,		mharl		45 Cib.	Town or	Landina	-4 Death	May	19	c. County of	~	6:40 P ^M
	Examin	er	Heritage Harbour					apol	Location o	or Death			anne A		ie i
	Funeral	1		S. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under		8. Date of Bir	rth			ace (State or Foreign ry)
	Director		129-20-0269 Usual Residence of Decedent	1 4 M 2□F	76	Yrs.	Months	Days	Hours	Min.	July 1	3,	1927 N	ew \	ork
	nylanc how		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10	d. Inside City Limits
	Ba-f.	Director	Maryland Anne A	rundel	Ann	apolis									1 Yes 2 No
	with th	Dire	10e. Street and Number	_			10f. Zip					150	itizen of Wha		-
	eath	erai	2616 Point Looke		edent Ever in U	S 13		401	snanic Ori	gin? (So			ted St		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If marked other than "natural", or Items 23a or 28a-f ehow other traumatic event, the Medical Examinations to indiffed at	by Funeral	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Fo	orces? 2 No Ne Dates: 1946-		If Yes, spec	12	Specify:	i, Puerto	ecify Yes or No Rican, etc.)		Black, \	White, e	etc.
9	2 hou		15. Decedent's	Education	1740	16a. Dece	dent's Usua	al Occupa	ition			16b. I	Kind of Busin		
21215-0036	ithin 7 19.	Completed	(Specify only highest Elementary/Secondary (0-12)		1-4or 5+)	life.	kind of wo DO NOT us	rk done d se retired	uring mosi)	t of work	ing				
21	filed within Hygiene. ther than "		47 5-4-4 Nove (5 - 16-4)	4		5	ales		40.11.4				tomob	iles	B
Maryland	12 should be filed within h and Mental Hygiene. 7 le marked other than " raumatic event, the Me.	Be	17. Father's Name (First, Middle, L. Lloyd Goossen	1 <i>51)</i>							e (First, Middle en Dool		n Sumame)		
7	should nd Me mark matic	ဥ	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	na Address	1			Al Route Numb		or Town Sta	te Zin i	Code)
	and 2 salth ar n 27 le		Betty Goossen/ w					,			e Anna				,
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Ę.,	4	П	23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that	caused the deat	h. Do not ent	er the mod	e of dying	, such as	cardiac o	or respiratory a	rrest,	_		Approximate Interval Between
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<u>=</u>		Соп									perfo	rmed? 2☐M	deat	h?	NO
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			Jon BI	we of	1)		I	19	520	7-1	MD	20	- Mie	42	20'04
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			For AMEND#5 5/27/04 1 - State RegistrarAACO HEALTH DE		Maryland		artment of H		Mental Hy	giene Reg. No. 2	004	18	ls 1
			1. Decedent's Name (First, Middle, Las	(1)					2. Date of De	eath Day	Year	3. Time of	Death
- 18 miles	Physici /Medio		Maria A. Garcia						May	19,	2004	5:15	P ^M
	Examir		4a. Facility Name (If not institution, give		er)		4b. City, Town, or		th	4c. Count	y of Death		
			1387 Greenway Dri		Ann (la usa la		Annapolis	if Under 24 Hrs	8. Date of Bi		Arunde		F i
	Funeral		5 Social Security Number 6. St 5 70 74 73 32 1	□M 2MF	Age (In yrs. Ia	Yrs.	Months Days	Hours Min	. (Month, Da	ay, Year)	9. Birthpli Count	ace (State o	or r-oreign
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	yland		10a. State 10b. County		10c. City	, Town or Lo	ocation				10	d. tnside Ci	*
	B Mar	ctor	Maryland Anne Aru	nd e l	Anna	apolis						1 🗆 Yes	2 X No
	or 28	Oire	10e. Street and Number			_	10f. Zip Code			10g. Citizen of	What Count	ry?	
	23a	Funeral Director	1387 Greenway Dri				21401			Spain			
	er de	nue	11. Marital Status	12. Was Decede	es?	S. 13.	Was Decedent of H If Yes, specify Cuba	_		- 14. Ha Bta	ce - America Ick, White, e		
36	rs aft	by F	1 ☐ Never Married 2XX Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2] If Yes, Give Year or Date	••	ļ	1⊠ Yes 2□ No	Specify: Sp	ain	Speci	y: Whi	te	
21215-0036	n 72 hours after death with the Maryland "naturel", or Items 23a or 28a-1 show valical Extratment be notified at	ed	15. Decedent's Ed	lucation			dent's Usual Occup			16b. Kind of B	Business/Ind	ustry	
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yla		ဥ	Juan Bolanos					Maria B					
Jar	12 short and risem.		19a. Informant's Name/Relationship (ype, Print)		19b. Maili	ng Address (Street a	and Number or H	lural Houte Numb	er, City or Town	, State, Zip i	Code)	
	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		Clemente Garcia / 20a. Method of Disposition	Husband	20b. Pl	ace of Dispo	Greenway sition (Name of	ADMINISTRAÇÃO AC	Annapoli Date	s ID 21		vn. State	
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Records, P.	uires that signed by Id be deta	þ	Part II. Other significant conditions of	ontributing to deat	,		, ,	en in Part I.		tobacco use con Yes 2 ∑ No		e cause of d	
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-			30. Name and address of person who				Print)	·	mo1 d 14:	11	21010		
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Physi /Med		Robin Ann Held						May 28,	2004	Year	1902 P M
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Directo		532-90-4181 Usual Residence of Decedent	1□M 2 ∏ F	38	Yrs.	Months Days	Hours Min	8. Date of Birth (Month, Day, 8/25/196	Year) 55	Coun	MN
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ING Z1Z13-UU35 ba filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	lent's Usual Occup kind of work done	pation during most of wo d)	rking	6b. Kind of B	usiness/Ind	lustry
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Maryis d 2 should th and Mer it is marks traumatic		19a. Informant's Name/Relationship	Type, Print)					ıral Route Number, (Code)
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To the within To the compl	Me	29b. Signature and title of certifier	A			29c. License	number	29d.	Date signed	(Month, Da	iy, Year)
		1 Cork	em)			0.C.1	M.E.	M	ay 29,	2004	Į.
5		30. Name and address of person who	completed cause	of death (Item			Street, E	Baltimore,	Mary]	and 2	21201
St Regist	ate	31. Date filed (Month, Day, Year)	1 2004 N	gistra s Signati	ure &	Sperte					
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State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 12:20 Mb May 2004 James L. Hicks /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Future Care Arnold If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months 1 [3M 2 □ F 23 1933 Maryland 70 Sept. Director 216-30-1276 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mudical Experimentmest be notified as 1 XYes 2 No Directo Maryland Anne Arundel Annapolis 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number USA 126 Hearne Ct. Apt. T121401 death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: Korean 72 hours after 1 ☐ Never Married 2 ☐ Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: þ 3 ☐ Widowed 4 ☑ Privorced Be Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7/s in and Mental Hygiene. 7 is marked other than "n Waxter's Children College (1-4or 5+) Elementary/Secondary (0-12) Center Youth Advisor 4 yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Evelyn Johnson James M. Hicks 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 i Md. 21401 613 Marti Lane Annapolis, Linda Boyd (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 'Department of Himportant: If Ite any injury or of Office. ©Burial 2 ☐ Cremation 3 ☐ Removal from State Hill Crest Memorial 5/21/04 Annapolis, Md. 4 Donation 5 Other (Specify) Gardens_{2.} Name and Address of Facility 21. Signature of Funeral Service Licensee Zavy H. Seese Mc6983 Wm. Reese & Sons Mortuary, 821 West St. Annapolis, Md shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death suchor soulor Acrident Immediate Cause (Final Physician years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the as attending a IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o. the 9 Unknown ۵ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Munknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has page 2 certificate 1 Yes 2 No Vital 25. Was case referred to medical examiner? ector 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No 2 funeral dir o this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t Certification: Division or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier D-40521 who completed cause of death (Item 23a) (Type, Print) 325 Kolpin Druce S 30. Name and address of person DK. OCHANIES egistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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				State of Marylan				ental Hy		1 10111
			1 State Registrar		Ce	ertificate of	Death		Reg. No ZUU	4 104 4
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last)	tall				2. Date of Dea		3. Time of Death 2. 159M
	Examin		4a. Facility Name (If not institution, give str	eet and number) Wede cal	Conle	1	or Location of Death	5	4c. County of I	
ľ	Funeral Director		5. Social Security Number 6. Sex 1 □ N	7. Age (In yrs.		/	Hours Min.	8. Date of Birt (Month, Date of Birt)	h y, Year) 9.	Arundal Birthplace (State or Foreign Country) arvland
	D		2 1 6 - 4 2 - 4 6 8 5 Usual Residence of Decedent 10a. State 10b. County	100 Cit	y, Town or	Longting		<u>ay 5 1</u>	74-3	10d. Inside City Limits
	a-f shor	ctor	Maryland Anne Aru		hian	LOGATION				tod. Inside City Limits
	with th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	it Country?
	eath	erai	5295 Sands Road	. Was Decedent Ever in U	S 13	20711	Hispanic Origin? (Spe	cify Ves or No.	USA 14 Baca	American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Importent: If Item 27 is marked other then "naturel", or Itema 23a or 28a-f show says injury or other traumatic event, the Medical Exciping rotal be notified at another.	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	Black, \	White, etc.
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ylar	Menta Menta arked atic ev	To B	Robert Smith	Sr.	,		Sarah	Randa1	. 1	
Maryland 21215-0036	nd 2 shall alth and 27 is m	ī	19a. Informant's Name/Relationship <i>(Type</i> Nalter Hall Jr. (o, Print) Husband)			and Number or Rura Road Lot			
Baltimore,	of Hei		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer	20b. P	Place of Dispernetery, cr	position (Name of ematory or other places to Cem	ce)	ate	20c. Location - City	
Ħ.	it. Pag rtment rtent: njury o		*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee			22. Name and Addre	3/	27/04	Annapol	is, Md.
Ba	Depa Impo sny is		Janny H. Ros	a. mcc483	, 1		e & Sons St. Ann	Mortu	ary, P.	A. 1401
п			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	itions that caused the deat	h. Do not e	DZL WEST nter the mode of dyi	ng, such as cardiac o	a political respiratory ar	rest,	Approximate Interval Between
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ords	w requires that the de been signed by the should be detached							1 🗆 Y	/es 2, 12 No 3 [Probably 4 Unknown
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ita	rtifica	Bec	25. Was case referred to medical				26. Place of Death			
>	nysic direc	To	examiner? 1 ☐ Yes 2 🛣 No Hos	spital: 1 🗖 Inpatient 2 🗆	ER/Outpati	ent 3 DOA Ott	ner: 4 🗆 Nursing Hon	ne 5 🗆 Resid	dence 6 Other (Specify)
o uo	Attending Physicien: ir death. ector: After this certifics by the funeral director, I		27. Manner of Death 1. ⚠Natural 5 ☐ Pending 2. ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Wo			now injury occurred	
Division of	i i ite	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		street, factory, office	2	8f. Location (S City or Tow		r Rural Route Number,
	To the Hospitel within 24 hours a To the Funeral Completely filled	edicai	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	cien: To the best of my kno r: On the basis of examina and manner stated.	wledge, dea tion and/or	ath occurred at the trinvestigation, in my	me, date and place, a opinion, death occurre	nd due to the o	cause(s) and manne date and place, and	or as stated. due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of pertifier	1 2		29c. Licens	se number	1	29d. Date signed (M	Ionth, Day, Year)
F) and	er Mi	\mathcal{C}	D	005 799	94	5/21	104
			30. Name and address of person who com	pleted cause of death (Item	1 23a) (Typi	Print) Best 1	alopa 1	Culo	215 L.	rapols MOZIKO
	Sta Registi		31. Date filed (Month, Day, Year) MAY 2 6 20	32. Registrar's Signa		Small a	Wad	200	CI.S MM	ago sinocipo
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			1- For State of Maryland	-	irtment of H tificate of L			iene 9g. No. 200	6 181.15
			Decedent's Name (First, Middle, Last)				2. Date of Deat Month	h Day Year	3. Time of Death
	Physici /Medio		Mildred E.	Hoff				2004	1:45 Рм
	Examir		4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center		4b. City, Town, or Annapoli	Location of Death		4c. County of De	nde1
Ī	Funeral Director		5. Social Security Number 579-40-0970 6. Sex 1 ☐ M 2 ☐ 7. Age (In yrs. In	_	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Nov. 5,		nthplace (State or Foreign Country) shington, DC
	p k		Usual Residence of Decedent 10a. State 10b. County 10c. City	Town or Lo	cation				10d. Inside City Limits
	Maryla fed at	ρ	Maryland Anne Arundel Crof						1XXXYes 2 □ No
	3a or 28e	i Direc	10e. Street and Number 1657 Fallowfield Court		10f. Zip Code 21114		11	0g. Citizen of What C	Country?
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene timportent: if item 27 is marked other than "natural", or items 23a or 28e-f show mit progress; if item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, I're Medical Exa. directional by notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Nas Decedent of Hi f Yes, specify Cuba I ☐ Yes 2∏ No	ispanic Origin? (Spe un, Mexican, Puerto F Specify:	city Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
5-0	72 ho 'natur	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa	ation during most of working	ng	16b. Kind of Busines	s/Industry
121	within	mp	Elementary/Secondary (0-12) College (1-4or 5+)		maker	1)		Own Hom	e
N	d be filed ental Hygie ced other c event, II	To Be Co	12 17. Father's Name (First, Middle, Last) Aubrey Dazi	e1		18. Mother's Name Reta	(First, Middle, M	Maiden Sumame) Atkins	on
Maryland	nd 2 should Ith and Men 27 is marke r traumatic	Ė	19a, Informant's Name/Relationship (Type, Print) Michael Biggs/Son		1			City or Town, State, Maryland	
Baltimore,	Pages 1 au ent of Hea nt: if item ry or othe		Ce	metery, crei	sition (Name of natory or other place Memorial ark		7	20c. Location - City o Davidsonvi	rTown, State 11e, Maryland
Balti	permit. I Departm Importer any inju		21. Signature of Funeral Service Licensee	22	. Name and Addres	1100		Evans Fun , Marylan	
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	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one) 29 Medical Examiner: On the basis of examinat and manner stated.	vledge, deat ion and/or in	h occurred at the tin vestigation, in my o	me, date and place, a opinion, death occurre	and due to the ca	ause(s) and manner a ate and place, and do	as stated. ue to the cause(s)
	To the within 2 To the complex	Me	29b. Signature and title of certifier		29c. Licens	y 804	2	9d. Date signed (Mod	
-			30. Name and address of person who completed cause of death (Item Robert T Peterson)	23a) (Type,	Print) ANUC	Ann	epelis	5-23- Mol 1	140/
	St Regist	ate	31. Date filed (Month, Day, Year) MAY 2 5 2004 32. Refistrar's Signa	ure	book				
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			1 - For State Registrar	State of Ma	rylan		artmen rtificate			and M		Re	g. No.	200	l.	184	16
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Las Macie Louise Aacie Louise 4a. Facility Name (If not institution, give	Holt			4b. City,	Town, or	Location o	of Death	2. Date o Month May		Day	2002	4 4	ime of De	ам
	Funeral Director	Ci	687 White Swa 5. Social Security Number 6. S 238-32-7453		(In yrs. 77	last birthday) Yrs.	If Under Months	Arno 1 Year Days	old If Under Hours	24 Hrs. Min.	8. Date of (Month) Feb.	Birth Day,	Year) 192	9. 8	Birthplace (
	Maryland a-f ehow	ctor	Usual Residence of Decedent 10a. State MD Anne A	rundel	10c. City	y, To wn or Lo	cation	Α	rnol							side City L	
	th with the 23s or 28	Funeral Director	10e. Street and Number 687 White Swan	Drive			10f. Zip	Code 21	012			10	g. Citize	on of What US			
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28a-f ehow any injury or other traumatic evant, the Medical Evantinal rulal be notified at Once.	ρ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Was Deced f Yes, spec 1 ☐ Yes 2		spanic Origin, Mexican Specify:	gin? (Spa , Puerto	ecify Yes o Rican, etc.	r No-)		I. Race - Ai Black, W Specify:			
Maryland 21215-0036	a within 72 ho piene. r than "netui the Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12		+)	life. I	tent's Usua kind of wor DO NOT us Homen	k done d e retired)	uring mosi	t of work	ing	11	6b, Kind	of Busine HC	me		
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	and 2 sho lealth and m 27 is m har traum		19a. Informant's Name/Relationship (Robert E. Holt,	* *	20h B		White	e Swa		ive,	Arno	ld,	MD		2		
Baltimore,	t. Pages 1 rtment of H rtant: If ite njury or ot		20a. Method of Disposition 1	y)	C	emetery, crem iter Ch	natory or of nurch	Ceme	tery	May	20, 2004	I	?ete	ers Tv	7p, P?	A	
Ba	Depa Impo any ii		21. Signature of Toneral Service Licer 23a. Part 1. Enter the disease, or com-	Uhr	the death	4	195 GC	ov. F	Ritch	ie H	.A. Sowy, So	eve	rna	Park Park,	MD 2	cal He 21146 oximate	
	Physician and // / / / / / / / / / / / / / / / / /	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or a) c.	st St consequence	CUN uence of):	cev								Inter	val Betwee et and Deat Year	
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/Medi	cal.			arrell		45 O'S T			May 1		004 Year	0350 P
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Funeral	Г	5. Social Security Number	6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24		Date of Bir (Month, Da	th		nplace (State or For untry)
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1	Physic /Medi Examir	cal .	Decedent's Name (First, Middle, Las Traykia M. Jone 4a. Facility Name (If not institution, give 132 Obery Court	S			wn, or Location	on of Death	2. Date of De Month May 11	Day 2004	Year hty of Death	3. Time of Death O
	Funeral Director		5. Social Security Number 6. Sec. 219-23-2618 Usual Residence of Decedent	□M 2(X)F 1	6 Yrs.	If Under 1 Y Months D	polis ear If Und ays Hour	der 24 Hrs. S Min.	8. Date of Bir (Month Da Feb 19	th	Mary	place (State or Foreign nto) "Iand
	within 72 hours after death with the Maryland ene. then 'naturel', or liems 23e or 28a-f show 's Medical ENE', in et must be routified at	Funeral Director	Maryland Anne A: 10e. Street and Number 116 Colney Dr.		Town or Lo	lis 10f.ZipCo	_{de}			10g. Citizen o	f What Cour	1M Yes 2 □ No
9036	nours after death	d by Funera	11. Marital Status X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	i	Was Decedent If Yes, specify			ecify Yes or No Rican, etc.)	- 14. R	ace - Americ ack, White, ify: B1	etc.
Maryland 21215-0036	Hygi ther int,	e Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 10th 17. Father's Name (First, Middle, Last)	ucation de completed) College (1-4or 5+) 0	(Give life.	dent's Usual O kind of work d DO NOT use n udent	one during m etired)		ng (First, Middle,	High	olis Scho	Senior
	d 2 should th and Men 7 Is marke treumatic	To Be	Herman Bynum 19a. informant's Name/Relationship (7 Rochelle Jones	ype, Print) (Mother)	19b. Mailir 16 C	ng Address (St	Ro	chell	e Jone Na Route Numbe Oolis,	er. City or Tow	n. State. Zio	Code)
Baltimore,	Page nent o ant: If ary or		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen:	Removal from State Beset)	Par		17/1981	5-18	3	20c. Location Annapo	lis,	
	permit. Departe Imports eny inji		23a. Part1. Enter the disease, or corting shock, or heart failure. List only commediate Cause (Final	lications that caused the death.	Do not ent	21 Wes	st St dying, such	. Ann	Morti apolis r respiratory ar	s. Md.	P.A. 2140	Approximate Interval Between Onset and Death
	/Medical Examiner	Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. GUNS HOT Due to (or as a conseque Due to (or as a conseque c.		J ₀	10 1	(EAD	-			
x 68760,	death certificate be executed e attending physician and of for use as the burial-transit	edicai	IF FEMALE:	Due to (or as a conseque								
o.	the y th iche	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3☐ th 5☐	Ectopic pregna Other (specify	()				ate of delive onth	ny Day Year
ords,	v requires been signi should be	Completed by F	Part II. Other significant conditions co	ntributing to death but not resulti	ng in the ur	nderlying cause	e given in Pai	rt I.		es 2 No	3 Proba	ably 4 Unknown
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Division of	or Attending Phys ifter death. Director: After this in by the funeral di	Certification: To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	1 Inpatient 2 E	Bb. Time of Injury OUD 1:52 e, farm, stre	28c. I	njury at Work? 1 □ Yes 2 l	Z No 2	ne 5 ☐ Reside 8d. Describe has SVBTEC 8f. Location (S. City or Town 32 OBER	ow injury occu T WPS treet and Num n, State)	rred SHO ber or Rural	Route Number,
	1 5 4 d	Medical (one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death and/or inv	restigation, in n	ny opinion, d	and place, a eath occurre	nd due to the c	ause(s) and m ate and place,	anner as sta and due to	ated. the cause(s)
	Mith To COU	<	29b. Signature and title of centifier 30. Name and address of person who co	ompleted cause of death (Item 2)	3a) /Type 1	(o.C.M.		2	9d. Date signe May 1	1, 200	,,
N.	Sta Registr			O, HD 32. Registrar's Signatur	11		Stree	t, Bal	timore,	Maryl	and 2	1201

DHMH 17 Rev 1/2001

ORIGINAL

			For Stata	State of Maryla	nd / Department of		ental Hygie	ne 2001	181.10
			Registrar 1. Decedent's Name (First, Middle, L	acti	Certificate of	Death	Reg. 2. Date of Death	No.	3. Time of Death
ı	Physici		George A.	Tohnson				Day Year	:/ - 44-A M
	/Medic Examin		4a. Facility Name (If not institution, g.	ve street and number)	4b. City, Town,	or Location of Death	May de	4c. County of Death	h,
			Future Car	e Chesape	ake Ar	nold	-	Annes	Arundel
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs	(f) Yrs. If Under 1 Year Months Day	r If Under 24 Hrs. s Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birth	hplace (State or Foreign untry)
	Director		Usual Residence of Decedent		80 115.		Sept. 14,1	923 121	nsylvania
	yland how		10a. State 10b. County	10c. C	ity, Town or Location				10d. Inside City Limits
	Se-f s	ctor	Maryland Anne A	rundel	Arnold				14 Yes 2 □ No
	with th	Director	10e. Street and Number	DK	10f. Zip Code	1.0	10g.	Citizen of What Co	untry?
	eath v	Funerai	305 Coll	12. Was Decedent Ever in	2/0	Hispania Origin? (Spe	Un Un	Ted State	es of America
က္	after d writen	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces?	12 - If Yes, specify Cu	Hispanic Origin? (Spe ban, Mexican, Puerto F	Rican, etc.)	Black, White	
2-0036	2 hours after death with the Maryland eturel', or items 23e or 28e-f show ical Experiment must be notified at	d by	3	If Yes, Give 1964 Year or Dates:	1 Yes 201N	o Specify:		Specify:	3/ack
15-(C1 60 CH	Completed	15. Decedent's I (Specify only highest g		16a. Decedent's Usual Occ (Give kind of work don life. DO NOT use retii	e during most of working	16b	. Kind of Business/I	ndustry
2121	within iene. ' then "	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	Sail R	60)	F	Edoral 6	mount
þ	e filed of Hyg other vent,	o i	17. Father's Name (First, Middle, Las	t)	1 0001101	18. Mother's Name	(First, Middle, Maid	den Surname)	uver in least
ylar	ould by Menta arked	To B	Herderson J	chrison		Marie-	Taxlor		
Maryland	ges 1 and 2 should be filed within 7: t of Health and Mental Hygiene. If item 27 Is marked other then "n or other treumetic event, Its Medi		19a, Informant's Name/Relationship	(Type, Print)	19b. Mailing Address (Street	A.A	0 1	y or Town, State, Z	ïp Code)
	1 and Healtl em 27		Cazelle Lynn (oa) 20a. Method of Disposition		Place of Disposition (Name of	en Naria		Columbia Location - City or T	MMD 21045
JOL	Pages nent of int: If it		1 Donation 5 ☐ Other (Spec	□Removal from State	cemetery, crematory or other pl	(ace)	class	The state of the s	*//-
Baltimore	artra orte inju		21. Signature of Funeral Service Lice	11/11	22. Name and Add	ress of Facility	3/0/	-110W/15	, V//IO
Ö	Depa Impo eny ii		> Sperikult		Miller's 1	Netropolitan	Chape 19:	2 Forest Dr	. Annow k MI
П			23a. Part1. Enter the disease, of conshock, or heart allure. Life or	plications that caused the dea one cause on each line.	ath. Do not enter the mode of dy	ring, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Acineto	bacter infe	ction of	hip		Onset and Death Weeks
	/Medical Examiner			Due to (or as a conse	quence of):		,		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conse	quence of):				
	cuted nd ransit	Examiner	that initiated events	C					
90,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a conse	quence of):				
68760,	the the	Physician/Medicai	•	d					
Box (death certific e attending p id for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr				23d. Date of deliv	verv
		sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2□Fet 4□Pregnant at time of 9□Unknown		cy		Month	Day Year
P.O.	ac a	Phy	9 Unknown						
	w requires that the sbeen signed by the should be detached	1 by	Part II. Other significant conditions	contributing to death but not re	suiting in the underlying cause g	IVen in Part I.	1 ☐ Yes	/	the cause of death?
Vital Records,	w requ	ompieted					24a. Was an		opsy findings available
Re	e la has	dwo					autopsy performed	prior to co	ompletion of cause of
ita	10	BeC	25. Was case referred to medical			26. Place of Death	1 Yes 2 1 (Check only one)	No 1 Yes	2 No
of <	ding Physicien: h. After this certific funeral director,	၉	examiner? 1 \(\text{Yes} 2 \(\text{No} \)		JETVOUIDALIBITE 3 DOA	ther: 4 🗌 Nursing Hom		6 □Other (Speci	ify)
on C	ling P	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury 28c. Injury		3d. Describe how in	jury occurred	
Division	deat deat ctor: y the	ertification:	2 Accident investigation 3 Suicide 6 Could not	De Blees of trium. At h	M 1 [Yes 2 □No	Rf Location /Street	and Number or Run	ral Route Number
<u>S</u>	el or A	Certi	4 Homicide determined	building, etc. (Speci	ify)	,	City or Town, Sta		ar riodie rvanber,
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edicai (29a. Certifier 1 Certifying P	hysician: To the best of my kn	owledge, death occurred at the attorn and/or investigation, in my	time, date and place, ar	nd due to the cause	(s) and manner as :	stated.
	thin 24	Medi	one) 29b. Signature and title of certifier	and manner stated.		ise number			
)	Z × Z		De Is	ht	-	54718		Date signed (Month,	
			30. Name and address of person who	completed cause of death (Ite	- 00-) CT D-i			<u> </u>	
			ALI IPAKCHI	116 De	fense Highn	ay, Suite	200 A	napolis, s	41) 21401
•	Sta Registr		31. Date filed (Month, Day, Year)	32. Resstrar's Sign	ature & Apoll				
	riegisti	- do	親A1. とり	AL		<u> </u>			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 L Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2004 Month 26, Anne Tarasevich Krueger May 6:10 p.m. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Futurecare, Pineview Clinton Prince George 8. Date of Birth (Month, Day, Year)
Dec. 22,191

9. Birthplace (State or Foreign Country)
Pennsylvania If Under 1 Year 5. Social Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday) Months Days Hours 1 □ M 2 □X 91 189-03-0073 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ XNo Maryland Charles Accokeek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11165 Overlook Drive 20607 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 Yes, Give 2 X No 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 3 U.S. Government Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Simon Tarasevich Katherine Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur F. Krueger Husband 1165 Overlook Dr., Accokeek, Md. 20607 20b. Place of Disposition (Name of cemetery, crematory or other place) June 2, 2004 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery Cheltenham, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Williams Funeral Home, P.A. 20640 M00668 4270 Hawthorne Rd., Indian Head, Md. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End Stage Alzheimers Disease Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

burial-tran

the

use as t

The law requires that the death certificate be executed

Physiclen:

or Attending

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

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Completed

Be

Certification: To

Medical

Department of Importent: If any Injury or

Physician

/Medical

Examiner

Funeral

Director

'neturel', or items 23e or 28e-f show digal Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. onto the filed T is marked other then "neturel", or ite nry or other treumatic event, " Water I Ex. ... nry or other treumatic event,"

Baltimore, Maryland 21215-0020

Funeral Director

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Completed

Be

death with the Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

History of Septicemia

Poor Oral Intake

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Tyes 2 □ No

25. Was case referred to medical examiner? 1 Yes 2 No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

27. Manner of Death 1 Matural 2 Accident

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined

Hospital:

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

1 Tyes 2 XNo

29a. Certifier (Check only one)

3 Suicide

4 Homicide

1 Certifying Physiclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 51520 29d. Date signed (Month, Day, Year) 05-28-2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bahram Pishdad, M.D., 1328 Southern Ave., S.E., Washington, D.C. 20032 31. Date filed (Month, Day, Year)

State Registrar

JUN 0 2 2004



To the Hospital within 24 hours e

ours efter death. erel Director: After this certifice filled in by the funeral director, i

DHMH 16 Rev 6/95

		1 - State Amend Item Registrar 1. Decedent's Name (First, Middle, L	ast)						2. Date of De		- O O r	3. Time of Death
Physicia /Medic		John Lyla Kalle	nbach '	John	Lyle Ka	allenl	oach		May	23 23	2 OO	+ 6:50 A
Examin	er	4e. Fecility Name (If not institution, g.) North Arund	ve street and number)	oit	al	11-	wn, or Locatio	n of Death	2	1	ounty of Deet	Anndel
Funeral Director			Sex 7. Age	72	. last birthday) Yrs.	If Under 1 \ Months C		er 24 Hrs.	8. Date of Bird (Month, Da Oct. 2	h	9. Birt	hplece (State or Foreig untry) WI
land wo		Usuat Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Loca	ation						10d. Inside City Limits
ith the Marylar or 28a-f ehow	ctor	MD Anne A	rundel				asaden	a				1 ☐ Yes 2 🛣 No
death with the Maryland me 23e or 28e-f ehow	ai Dìre	10e. Street and Number 413 Lakeshore Di	rive			10f. Zip Co	21122			10g. Citizer	n of What Co U	untry? SA
je 2 2	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 [XYes 2 □ N If Yes, Give Year or Dates:	10	952	as Deceden Yes, specify ☐ Yes 2[€]			cify Yes or No Rican, etc.)	1	Race - Ame Black, White Decify:	
Z I 3-0000 Ithin 72 hours after ie. "natural", or Ite	eted t	15. Decedent's E (Specify only highest gi	 Education		16a. Decede	nt's Usual C	ccupation	ost of workin	na	16b. Kind	of Business/	Industry
d within giene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. DO	O NOT use i	Manage		.9	Depar	ctment	of Defense
Deficiency (Mary Plating 2 1 permit. Pages 1 and 2 should be filled with permit. Pages 1 and 2 should be filled with Important: If item 27 is marked other than any injury or other traumatic event, the Appreca.	To Be C	17. Father's Name (First, Middle, Las John Lyle Kalle	,					ther's Name abel M	(First, Middle, lalone	Maiden Su	mame)	
e, Mal. tand 2 sho Health and m 27 is mu ther traum		19a. Informant's Name/Relationship Rose Kallenbach							<i>l Route Numbe</i> Isadena		own, State, 2 21122	lip Code)
9 ° = 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Spec			Place of Disposit cometery, crema dar Hill	tory or other	r place)	May	27, 2004		ion - City or oklyn,	
permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Lice	ensee	20	Bar	ranco	& Sons	s. P.A	. Seve	rna Pa	ark Fu	neral Home D 21146
		snock, of rear failure. List only	nplications that caused one cause on each line	the dea	th. Do not enter	the mode o	f dying, such a	as cardiac of	r respiratory ar	rest,	ILK, M	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Net o Due to (or as a	C S		Pro	stal	e (anc	RY		Oriset and Death
Examiner	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a	conse	quence of):							
and -transit	Examiner	side any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to fee en									
ate be executed thysicien and the burial-transit	icai E		Due to (or as a	consec	quence or):							
eath certifica attending ph for use as th	ed	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			-				23d	. Date of deli	ven/
It the death cert by the attending tached for use a	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown			ctopic pregr Other (<i>specit</i>					Month	Day Year
The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transt	Ď	Part II. Other significant conditions	contributing to death bu	t not res	sulting in the und	erlying caus	e given in Par	t I.		es 2 N		the cause of death?
or Attending Physician: The law requires that the dark redeath. Director: After this certificate has been signed by the lin by the funeral director, page 2 should be detached	Completed								24a. Was a autop perfor	sy	4b. Were aut prior to c death? 1 \(\sum Yes\)	opsy findings available ompletion of cause of
ystcian: Th	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		I S D / O · A · · · · · ·	a = 2 = 2 = 2	Other		(Check only or			
ding Phys h. After this funeral di	on: To	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day		28b. Time of Injury	3 ☐ DOA 28c.	Injury at Work?		ne 5 Resid 8d. Describe h			ify)
r Attending Physician: er death. rector: After this certification by the funeral director.	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not to determined	De Dinne of tois	ry - At h	ome, farm, stree	М	1 Yes 2		8f. Location (S City or Tow	treet and No	umber or Rui	al Route Number,
5 10 00 00 00 00 00 00 00 00 00 00 00 00	cal Cer	29a. Certifier (Check only) Certifying P (Check only) Medicel Exa	hysician: To the best of miner: On the basis of	f my kno	owledge, death o	ccurred at the	ne time, date a	and place, a	nd due to the c	31150/5) 300	i manner as	stated.
To the H within 24 To the F complete	Medical	29b. Signature and title of certifier	and manner stat	ed.	ation and/or inves		cense number					
F 3 F 8		Adeninka	O. Lany	lem	omb	-	059	728	3	May	gned (Month) 23	2004
	- 1				-	_						

			1 - For State Registrar	State of Maryla	ınd / Depa		t of He		-	-	004	1842
	Physic /Medi		Decedent's Name (First, Middle, Last, BETTY DO) RIS FANNIN L	EADINGH	AM			2. Date of De Month May	Day 26,	Year 2004	3. Time of Death 11:45 Am
	Examir		4a. Facility Name (If not institution, give 201 East 8th Stre	et		Fr	eder			Fre	ty of Death	
	Funeral Director		5. Social Security Number 6. Sec. 401–40–8543		s. last birthday) 72 Yrs.	If Under Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Feb. 2	**************************************	9. Birthp Cour Kent	place (State or Foreign MCky UCky
	the Maryland	ector	10a. State 10b. County Maryland Frederic		City, Town or Lo	ck						1 d. Inside City Limits 1 Yes 2 No
	s 23a or 3	ral Dir	10e. Street and Number 201 East 8th Str			10f. Zip	2170				f What Cour U.S.A	•
900	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f ehow he Madical Exe uiter, sast be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Vas Deced Yes, spec		panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14. Ra Bl Spec	ace - Amend ack, White, ify: W	
21215-0036	d within 72 h piene. r then *natu	omplete	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	cation e <i>completed)</i> College (1-4or 5+)		kind of worl OO NOT use	k done du e retired)	ion uring most of work	ing	16b. Kind of		ŕ
Maryland ?	should be filed within and Mental Hygiene. marked other then umatic event, the Market	To Be C	17. Father's Name (First, Middle, Last) George Fannin					18. Mother's Nam Dora Lov	ve .	Maiden Suma	nme)	
	1 and 2 sh Health and Iom 27 Iom		19a. Informant's Name/Relationship (Ty, Meredith P. Leadin;	gham (Husban	d) 201 1	East 8	8th S		Frederic	er, City or Town	n, State, Zip y land	Code) 21701
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importents: if Item 27 ie marked other then "naturel", or Items 23a or 28a-f ehow maryl injury or other traumatic event, the Macinial Exertifier and be notified at once.		20a. Method of Disposition 1 X Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Incense	Plu		e. Comn	n. Ce	em. 5/29/ of Eacility & S			Co.,	Kentucky
8760,	Physician /Medical Examiner	cal Examiner	23a. Party Enter the disease, or complishock, or heart failure. List only on immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Metastati Due to (or as a conse	ath. Do not enter Solution of	<u> 10 NOF</u>	of dying,	IARKET ST	REET, I	REDERI	CK, MI	21701 Approximate Interval Between Onset and Death
O. Box 6	the death certific y the attending p iched for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic pred Other (spec					ate of deliver	ry Day Year
cords, r	es ti	ρ	Part II. Other significant conditions con	tributing to death but not re	sulting in the un	derlying cau	use given	in Part I.	23e. Did to	V		e cause of death?
e L	The law ate has b page 2 st	e Completed	25. Was case referred to medical					26. Place of Death		med? 2000	Were autop prior to com death? 1 \(\text{Yes} \) 2	sy findings available pletion of cause of
0	ding Physician: h. After this certific funeral director,	n: To B	27. Manner of Death	28a. Date of Injury	ER/Outpatient	-	Other:	4 Nursing Hor		ence 6 Oth		
JIVISION	To the Hospital or Attending Physician: Anihin 24 hours alter death as alter death Anihin 24 hours alter death Anihin 25 hours alter death Ani	Certification:	1 Anatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	(Month, Day Year) 28e. Place of Injury - At houlding, etc. (Special Control of the Control of t	Injury nome, farm, stre	M et, factory,		s 2 🗆 No	8f. Location (S. City or Town	treet and Numb n, State)	per or Rural	Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	edical Ce	29a. Certifier (Check only one) 1 Certifying Physical Check only one)	ician: To the best of my kn er: On the basis of examinand manner stated.	owledge, death ation and/or inve	occurred at estigation, in	the time, n my opin	date and place, a ion, death occurre	nd due to the c	ause(s) and ma ate and place,	anner as sta and due to t	ted. the cause(s)
	To the Comp	Me	29b. Signature and title of certifier	olla MI)		License n	8184		9d. Date signe 5/27	104	
I	Stat	e	30. Name and address of person who con EIham ESK 31. Date filed (Month, Day, Year)	100	MD	50	I W	The str	et Fre	ederick	CIM	021701
	Registra		MAY 2.7	and bane		9	1					

Randy Edward Leonard 04-0 MAN

unpend item#23a,27,PFR ME,0832,6/22/04eg Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

J3:	036	•	For State Registrar	State o	f Marylan		artment rtificate			ınd M	ental Hy	/giene Reg. No	20	04	1842	3
	Physici	an	1. Decedent's Name (First, M	iddle, Last) ward Lecnard			_				2. Date of D Month May 20	Da	04	Year	3. Time of Death	M
	/Medio Examin		4a. Fecility Name (If not institu				· .		Location o		-	4c.		of Death	10055 A	
	Funeral Director		5. Social Security Number 216 94 6968	1 ⊠ M 2□F	7. Age (<i>In yr</i> s. 40	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bi (Month, D	ay, Year)			lece (State or Fore htry) ington DC	ign
)	Maryland If show	tor	Usual Residence of Deceden 10a. State 10b. Con Maryland Calx	unty		y, Town or Lo								1	0d. Inside City Lim 1 ☐ Yes 2 ☐	
	h with the	Funeral Director	10e. Street and Number 3715 Spruce	e Road			10f. Zip 206						izen of V ed St	What Cour ates	ntry?	
920	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23e or 28e-f show event, tre Medical Exambra must be notified at	þ	11. Marital Status 1 Never Married 2 3 Widowed 4 Divo	Armed For Married 1 ☐ Yes If Yes, Gin	/8	l l	Was Deced If Yes, spec		spanic Origin, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or N Rican, etc.)	0-	Blac	e - Americ k, White, white		
21215-0036	within 72 horens. ene. than "nature ne Medical E	Completed	15. Dece (Specify only hi Elementary/Secondary (0- 12th	ident's Education ighest grade completed) College (*	1-4or 5+)	16a. Dece (Give life.	dent's Usua kind of wor DO NOT us	l Occupa k done d e retired	ation during most	t of worki	ng	16b. K	ind of Bu	usiness/In	dustry	
Maryland 2	should be filed and Montal Hygie marked other imatic event, II	To Be Co	17. Father's Name (First, Mid Roger E. Is						18. Mothe	r's Name	(First, Middle Marie	e, Maiden Kinne		18)		
	and 2 shousalth and N n 27 is me		19a. Informant's Name/Relate Roger E. Leonard			3937 \$	Shamroo	k Ct			al Route Numb	20676				
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Ia marked any injury or other traumatic e once.		`4 □Donation 5 □Othe		State Sou	Place of Dispondering Creating Management Management Management (Management Management M	matory or o	Gan				Dunki	rk Ma	rylan	own, State	
Balt	permit. Depart Import any inj		21. Signature of Funeral Ser	usch		44	05 Broo	mes :	Is. Rd	. Por	usch Fun t Republ	ic MD		6	Approximate	
	/Medical Examiner	Examiner	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Usassa Cussassa or injury that initiated events	a. Due to b. Due to c.	mia (or as a consec	quence of):									Interval Between Onset and Death	
Box 68760,	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnar in the past 12 months?	dt 23c. If yes, ou	(or as a consector a	ancy al death 3[⊒Ectopic pr							te of delive	ery Day Year	
P.O. E		Physic	1 Tes 2 No 9 Unknown Part II, Other significant coi	9□ Unkn	Z-111-40		Other (sp		on in Part I		23e Did	Itobacco	use cont	ribute to ti	he cause of death?	,
Il Records,	The law requires are has been signings 2 should be	Completed by	Tatili. Otto Significant								24a. Wa aut			3 Prot	pably 4 Unknot upsy findings availad mpletion of cause 2 No	ble
n of Vital	ding Physician: Th n. After this certificate funeral director, pag	lon: To Be		Hospital: 1 🛣 28a. Date (Mor	Inpatient 2 Continuity of Injury th, Day Year)	ER/Outpatie		8c. Injur	er: 4 🗆 Nu	ırsing Ho	me 5 Res 28d. Describe	sidence			ýy)	
Division	or Attendition deatl	Certification:	3 Suicide 6 □ C		of Injury - At h ing, etc. (Speci				165 2			(Street ar		er or Rura	al Route Number,	
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 ☐ Cer (Check only 2 ☑ Med one)	tifying Physician: To th lical Examiner: On the b and mar	e best of my kn asis of examin ner stated.	owledge, dea ation and/or in	th occurred ivestigation	at the tin	ne, date ar pinion, dea	nd place, ath occurr	and due to the	e, date an	d place,	and due to	o the cause(s)	
	To the within 2 To the comple	X	29b. Signature and tifle of ce	An M	1				M.E.					d (Month, 200	Day, Year)	
			30. Name and address of pe	29 AN		111		Str	eet,	Balt	imore,	Mar	ylan	d 21	201	
	St Regist	ate rar	31. Date filed (Month, Day,	0	Registrar's Sign	sature										

	1	For State Registrer		Int in Black I Maryland / De Co		t of H	ealth a		ental Hyg		-	4 1842	L
Physicia /Medica	n	1. Decedent's Name (First, Middle, Las Sara K. Long	")						2. Date of Dea Month May	Day 15	Year 200	3. Time of Death 4 11:45 A	M
Examine		la. Facility Name (If not institution, give Ginger Cove Heal	street and numbe th Cente	r) r	4b. City,		Location o apoli	s		1	nne Ar		
Funeral Director		207-30-0134	х ЖЖ Б	Age (In yrs. last birthda 81 Yrs.	Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth Month, Pay 9/5/15	22 ^{r)}	C	rthplace (State or Foreign country) rth Carolina	
Aaryland f show	.	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Ar	undel	10c. City, Town or	Location	Aı	nnapo	lis				10d. Inside City Limits 1 ☐ Yes 2 🔀 No	
with the Na or 28a-	Funeral Director	10e. Street and Number 4000 River Cresce	nt Drive		10f. Zip	Code	2140)1	1	0g. Citiz	en of What C		
0 0	۱ څ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Date:	X.No	3. Was Dece If Yes, spe		ispanic Origin, Mexican	gin? (Spe , Puerto l	ocify Yes or No- Rican, etc.)		4. Race - Am Black, Wh Specify: W		-
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be liled within 72 hours all Opportment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examplace.	Completed	15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)	ucation de com <i>pleted)</i> College (1-40	(Gi	cedent's Usu ive kind of wo a. DO NOT u	al Occupant done of se retired	during most ()	of worki	ng	16b. Kin	d of Business	s/Industry HOMe	
land in its and its and its event,	To Be C	17. Father's Name (First, Middle, Last) Conrad Helms					18. Mothe		(First, Middle, K. Rosie		Sumame)		
Mary nd 2 shou aith and M 27 is mar		19a. Informant's Name/Relationship (7 William T. Long			ailing Address				Route Number				
Baltimore, sernit. Pages 1 ar Department of Hea mportant: If teminy injury or othe ance.		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		20b. Place of Dis cemetery, c	rematory or	other place	etery		14/2004		ation - City o	r Town, State S. MD	9
Balti permit. Departm Importa eny inju		21. Signal in Juneral Service Licen	3 / K	10w					nn M. Ta ter Anr			ral Home D 21401	
Physician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. DE	sed the death. Do not on the line. EMENT (Fast as a consequence of):		de of dyin	g, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death	
Examiner	ner	Sequentially list conditions,	b	as a consaquence of):									-
	ai Examin	cause. Enter Underlying Cause (Disease or injury that inditated events resulting in death) Last	cDue to (or	as a consequence of):									-
0 20	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ② No 9 □ Unknown		2 Fetal death	3 □Ectopic p 5 □ Other (s _i					2	3d. Date of de Month	elivery Day Year	
ds, P.O	۾	Part II. Other significant conditions of	ontributing to death	n but not resulting in the	e underlying	cause giv	en in Part I.			bacco us	2	to the cause of death? Probably 4 Unknown	n
I Rec	Completed								24a. Was a autops perfor	med?	24b. Were a prior to death?		9
of Vita Physician: r this certitic ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Oth Oth	000		(Check only or			//	7
Vision of Attending Physic death. ector: Atter this by the funeral di	Certification; To	27. Manner of Death 1	28a. Date of li		e of y M	28c. Injun Wor	4 2-140	No	me 5 Resid	ow injury	occurred		1
Divisit To the Hospital or Attent within 24 hours atter death To the Funeral Director: completely tilled in by the	Certific	3 Suicide 6 Could not be 4 Homicide determined	200. Flace 01	Injury - At home, farm, etc. (Specify)	street, factor	y, office			28f. Location (S City or Tow		Number or F	Rural Route Number,	
Hosp 14 hou Funer fely til	edicai			est of my knowledge, de s of examination and/or stated.									
To the within 2 To the comple	Ň	29b. Signature and title of certifier	`			~	e number	08			signed (Mor	nth, Day, Year)	
		30. Name and address of person who Dr. William Dabl		of death (Item 23a) (Typ Peninsula		Road	Arn	old,	MD 21	012			19
Star Registra		31. Date filed (Month, Day, Year) MAY 2 5		far's Signature	Some	E)							
DHMH 17 Rev 1/20		nini 3		ORIG	INIAI								_

ORIGINAL

			1 - For State RegistraAMEND ITEM	State of #26 PER	Marylan VERB, PI	d / Depa G83 HY Cei	artment of I	lealth a Death	and M	ental Hyg	giene Reg. No. 2 (04	18425
	Physici	an	1. Decedent's Name (First, Middle,	Last)	-					2. Date of Dea Month	Day	Year	3. Time of Death
N	/Media		RUTH	M			LILLY		-1.5	May		2004	2:50A. ^M
	Examir	ier	4a. Facility Name (If not institution, Doctors Communi				4b. City, Town, o Lanha		or Death		4c. County		orge's
	Funoval				. Age (In yrs.	last birthday)	If Under 1 Year	If Under		8. Date of Birth			place (State or Foreign
	Funeral Director		579-36-7562	1 □ M 2 🛱 F	9	93 Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day Dec . 24	71910	Texa:	ntry)
	۵ ,		Usual Residence of Decedent 10a. State 10b. County		10c Cib	y, Town or Lo	reation					1	0d. Inside City Limits
	shor	5		George's		ltsvil							1 ☐ Yes 2X No
	the N	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Cour	ntry?
	3a or	<u> </u>	5400 Cordwall P	lace				20705	5		Ur	nited	States
	death	Funeral	11. Marital Status	12. Was Deced Armed Force	lent Ever in U.	S. 13.	Was Decedent of I	Hispanic Ori	igin? (Spe	cify Yes or No-	14. Rac	ce - Americ	
စ္တ	d within 72 hours after death with the Maryland jiene. r than "natural", or Itams 23a or 28a-f show The Medical Examiner must be notified at	y Fu	1 Never Married 2 Marrie	d 1 ☐ Yes 2 If Yes, Give	XNo		1 ☐ Yes 2 ☑ No			mazin, otoly	Specif		
21215-0036	hours tural',	ed by	3½ Widowed 4 □ Divorced 15. Decedent's	Year or Dat	es:		dent's Usual Occur				16b. Kind of B		
5		olete	(Specify only highest	grade completed)	45-1	(Give	kind of work done DO NOT use retire	during mos	t of working	ng	TOD. KING OF D	43/10/34/11	austry
212	filed within Hygiene. othar than "	Completed	Elementary/Secondary (0-12)	College (1-4	4or 5+)	sel	f employe	ed			Caregi	.ver	
פ	be filed ntal Hygid ad othar event,	Bec	17. Father's Name (First, Middle, L.	ist)	On.	1		-		(First, Middle,	Maiden Suman		
ylai	ould be I Mental I narkad o	2	Edward		CO.	leman			enia				ıston
Maryland	는 CE		19a. Informant's Name/Relationshi Don H. Lilly -s				ng Address (Street Joplin S				-		
45	an eal m		20a, Method of Disposition		20b. P	lace of Dispo	sition (Name of	1		ate	20c. Location	_	
ဝို	ages nt of nt of		1 Burial 2 Cremation			ametery, crar	natory or other pla itan Crer	natory	z 5/1	2/2004		•	ia, Virgini
Baltimore,	permit. Pages 1 Department of H Important: If Ita any injury or ott		. 4 □ Donation 5 □ Other (Special Signature of the fall service Line)			_ 8	Name and Addre	ess of Facilit	ardt	Funera			and 20705
	40144		23a. Part1. Enter the disease, or c	omplications that cau	used the death							aryra	Approximate
	Physician		shock, or beart failure. List of Immediate Cause (Final	nly one cause on eac	ch line.			Eum					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		r as a consequ		7 70		0 17	7 4			
	Examiner		Sequentially list conditions	b									
-	D ##	lner	Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a curiseq	uanca or).							
	and and I-trans	Examine	that initiated events resulting in death) Last	c. Due to (or	r as a consequ	uence of):							
8760,	sate be executed obysician and the burial-transit			330,000									
687	ficate physis the	olba		0.							1000		
Box (The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			Ectopic pregnanc				23d. Da	te of delive	ery
	death	icla	in the past 12 months? 1 ☐ Yes 2 ☒ No		th 2 ☐ Fetal nt at time of d		Other (specify)	·····			Mo	onth	Day Year
0	that the de ned by the a detached	Phys	9 Unknown					1. 8. 41		nos Dista			ne cause of death?
	res th signed be d	þ	Part II. Other significant condition	S contributing to dea	ith but not resi	uiting in the u	noerlying cause gr	ven in Parti.		239. Did to	V.	3 ☐ Prob	
P	A require	Completed											
3ed	has has	d m	SEPSIS							24a. Was a autop	med?	death?	psy findings available inpletion of cause of
a	i cian: The la certificate has rector, page 2	9 0	25. Was case referred to medical			 -		OC Place	of Death	1 ☐ Yes (Check only or	7171	1 🗌 Yes	2□ No
of Vital Records,	Physician: r this certifica ralldirector, p	To Be	examiner?	Hospital:	patient 2 🗆	ER/Outpatier	nt 3□ DOA Ot	han			ence 6 Oth	er (Specif	")
	g Phy ter thi		27. Manner of Death	28a. Date of (Month)		28b. Time o	-				ow injury occur		
joi	Attanding F r death. ector: After by the funer	atlo	1XXNatural 5 Pending 2 Accident investiga	ition		,7		Yes 2□	No				
Division	al or Attand safter death il Director: /	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Place 0	of Injury - At ho g, etc. <i>(Specif</i>)	ome, farm, str	reet, factory, office		2	28f. Location (S City or Tow		er or Rura	l Route Number,
Ω	urs af urs af arai D		To cathing	Dhusisian Tathah	and of my leng	urladas danti	b annumed at the ti	- data an	d place a	and due to the e	acusa(a) and ma		atad
	To the Hospital or within 24 hours after To the Funaral Director Completely filled in the Funara Director Completely filled in the Funara Director Completely filled in the Funara Director Completely filled in the Funara Director Completely filled in the Funara Director Completely filled in the Funara Director Completely filled in the Funara Director Completely fil	edical		Physician: To the b xaminer: On the bas and manne	sis of examina								
	o the	Me	29b. Signature and title of certifier	1		`	29c. Licen	se number		2	29d. Date signe		
	1		> Cally	Her-			D52	2299	1		May 1	11, 20)04
	1		30. Name and address of person					/		live -			THE STATE OF THE S
			Colin Ottey, M.I				King High	nway I	anha	m, Mary	land 20	706	
		ate	31. Date filed (Month, Day, Year)		gistrar's Signa	ture &	Spark						
	Regist	ell	PI IMIN	_00T		/	//						

		1 - For State Registrar	State of M		partment of leartificate of		Mental Hygi	ene g. No. 2004	18426	
Physic /Med Exam	ical	Decedent's Name (First, Middle, La JAMES IVAN MU 4a. Fecility Name (If not institution, given	LLEN		4b. City, Town,	or Location of Dea		Day Year 8 2004 4c. County of Death	3. Time of Death 4:00 A	
Funera Directo		174-30-9962		ge (In yrs. last birthda 65 Yrs	y) If Under 1 Year Months Days			MONTGOME Year) 9. Birth Cou	ERY place (State or Foreign intry) PA	
Ne Maryland	Director	Usual Residence of Decedent 10a. State 10b. County MD MONTG	OMERY	10c. City, Town or ROCKV	LLE				10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
death with the Maryland ems 23a or 28e-f show	Funeral Dire	1300 CORAL SE 11. Marital Status	A DRIVE 12. Was Decedent Armed Forces?	Ever in U.S. 1	10f. Zip Code 208. 3. Was Decedent of If Yes, specify Cul	Hispanic Origin?	(Specify Yes or No-	lg. Citizen of What Cou USA 14. Race - Amen Black, White,	ican Indian,	
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours atter death with the Marylan f Health and Mental Hyglene. It health and Mental Hyglene. Item 27 is marked other than "natural", or items 23s or 28e-1 show other traumatic event, the Medical Execution Constitution.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gr.	1 Yes 2 No	Specify:	Specify: WH					
nd 2121 e filed within al Hygiene. other than	Be Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last		LAW ENFORCEMENT						
Maryland nd 2 should be file lith and Mental Hy 27 is marked oth	ToE	JAMES THOMAS 19a. Informant's Name/Relationship (GUVHER MULLEN	Type, Print)			t and Number or F	ERINE SW Rural Route Number, ROCKV	City or Town, State, Zij	p Code) 20851	
00		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specia	Removal from State by)	20b. Place of Discemetery, of	sposition (Name of trematory or other pla RICK CREI	MAT. 5/	Date 2	Oc. Location - City or T	own, State	
Baltimo		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused	d the death. Do not		FUNERAL 86, B	ARNESVIL		20838 Approximate Interval Between	
death certificate be executed with the set of the set o		Immediate Cause (Final disease or condition resulting in death) S. uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of): a consequence of):	ON SHALL	CUNG	GARCINOI	MK :	Onset and Death 22/WONTES	
Box 6 eath certifi ettending	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death	3 □Ectopic pregnand 5 □ Other (specify) _	ey		23d. Date of delive	ery Day Year	
det det	Ď	Part II. Other significant conditions	contributing to death b	ven in Part I.	23e. Did tobacco use contribute to the cause of death Yes 2 No 3 Probably 4 Unkn					
I Re(The lavate has	Be Completed	25. Was case referred to medical examiner?				26. Place of De	24a. Was an autopsy perform 1 Yes 2	prior to co death? No 1 ☐ Yes	opsy findings available impletion of cause of	
Phy Printer at contract of	ဥ	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		ry 28b. Time	o of 28c. Inju	her: 4 Nursing my at ork? Yes 2 No	Home 5 € Residence 6 □Other (Specify) 28d. Describe how injury occurred			
Divided or purs efter the Dirich Street Diri	ai Certification;	3 Suicide 6 Could not be determined	City or Town,	eet and Number or Rura State) use(s) and manner as s						
To the Hos within 24 ho To the Fun completely	Medical	(Check only 2 Medical Example) 290 Signature and title of certifier	miner: On the basis of and manner st	f examination and/or	investigation, in my	opinion, death occ	curred at the time, dat	e and place, and due to d. Date signed (Month,	o the cause(s)	
5	tate	30 Nagle and address of person tho		leath (Item 23a) (Type 27 0 -)	Print)	CENCE	RARIVE,	Rockville	MARYLAND ZOSTI	
Regis	trar	MAY 2	3 2004 ▶ €	E par	~ jugo	VICE				

	,	1 - For State Registrar		Maryland / Dep		ealth and M	lental Hyg	giene	04 18427		
Physicia /Medica Examine	al	1. Decedent's Name (First, Middle, L James Stanley M 4a. Fecility Name (If not institution, gi	agee, Sr	r)	4b. City, Town, or I		2. Date of Dea Month May	Day	Year 3. Time of Death 7:10 a M		
Funeral Director		220-26-0704 Usuel Residence of Decedent		ge (In yrs. last birthda 72 Yrs.		inster If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July		roll 9. Birthplace (State or Foreign Country) MD		
und 21215-003 be filed within 72 hours a ltal Hygiene. Id other then "natural", c event. The Medical Exam	To Be Completed by Funeral Director	10a. State 10b. County MD Carr 10e. Street and Number 2005 Ridge Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced (Specify only highest gi Elementary/Secondary (0-12) 11 17. Father's Name (First, Middle, Las John Joseph Mage 19a. Informant's Name/Relationship	12. Was Deceden Armed Forces 1 17 Yes 2 [18 Yes, Give Year or Dates Education ade completed) College (1-4or	t Ever in U.S. 13 ? No : : : : : : : : : : : : : : : : : : :	Vestminster 101. Zip Code 211 Was Decedent of His, if Yes, specify Cuban 1 Yes 2 No edent's Usual Occupate e kind of work done du DO NOT use retired) ustodian	57 panic Origin? (Spe Mexican, Puerto I Specify: ion ring most of workin 8. Mother's Name Virgie N	cify Yes or No-Rican, etc.) og (First, Middle, Model of Pice)	Black, Specify: 16b. Kind of Busi Sacred I St. Johr Maiden Sumame)	American Indian, White, etc. White iness/industry Heart and n School		
Baltimore, Marylis permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 is marke any injury or other traumatic oppe.		Trene Magee/wife 20a. Method of Disposition © Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice)	Removal from State fy)	200. Place of Disposemetery, con	5 Ridge Roa constion (Name of constion of other place) n Memorial 12. Name and Address ritts Funer	5/27/ Gardens of Facility cal Home	inster, 2004	MD 211 20c. Location - Ci Finksby	ty or Town, State		
176	icai Exam	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Betwee Onset and Death Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
death certific	nysician	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	4□Pregnant a 9□ Unknown	2 Fetal death 3 time of death 5	□Ectopic pregnancy □ Other (specify)	in Part I.	23e. Did tob	23d. Date o Month	f delivery Day Year te to the cause of death?		
The law requirate has been a page 2 should	naladulona		- obstre		LORASI.		1 Yes 24a. Was an autopsy perform 1 Yes 2	24b. Wer prior dear	Probably 4 Unknown e autopsy findings available to completion of cause of		
Affe Ling	2	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of In	ry 28b. Time o	nt 3 DOA Other: 1 28c. Injury at Work? M 1 Yes	s 2 □ No	e 5 y Fesiden 3d. Describe how	nce 6 Other (Specify) r Rural Route Number,		
To the within 2 To the comple	medical	29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who	and manner st		29c. License ni	umber	at the time, dat	d. Date signed (M	due to the cause(s)		
State Registrar		BI. Date filed (Month, Day, Year) MAY 2 5		ar's Signature	forte	ode 1	CAU	USTM.	nster MD		

		1	State of Maryland	/ Depa		t of H	ealth a		-	giene	2111114	8	28	
			1. Decedent's Name (First, Middle, Last) 2. Date of Death Month								y Year	3. Time of	Death	
	Physicia /Medic		James Alexander Meiklejohn						May	25	, 2004		A ^M	
	Examin		4a. Facility Name (If not institution, give street and number)			_	Location o	f Death			County of Deet			
			Anne Arundel Medical Center		Annap If Under		If Under :	24 Hrs	9. Data of Bi		ne Arun			
	Funeral Director		5. Social Security Number 216-44-6386 0. Sex 1.04M 2□ F 57 Usual Residence of Decedent	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D Nov. 1	1, 1	946 Mar	thplace (State of buntry) yland	r Foreign	
	lend wo		10a. State 10b. County 10c. City, T	own or Lo	cation							10d. Inside Cit	ty Limits	
	Mary Les	ţo	Maryland Anne Arundel Annap	olis								1 X Yes	2 🗌 No	
	h the	Director	10e. Street and Number		10f. Zip	Code				10g. Cit	izen of What Co	ountry?		
	238 c	aiD	177 Acton Road		2140						ed Stat			
	r dee	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put						cify Yes or N Rican, etc.)	0-	 Race - Ame Black, Whit 			
Maryland 21215-0036	d within 72 hours after deeth with the Marylend place than "natural; or Items 23s or 28s-f show the Madical Evaluation notified at	þ	Year or Dates:							Specify: White				
5	"natu	ete	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usua kind of wo DO NOT us	rk done d	luring mosi	t of worki	ng	16b. K	b. Kind of Business/Industry			
121	within	Completed	Elementary/Secondary (0-12) College (1-4or 5+)			56 / O(II/ BO)	/			m				
d 2	be filed withi tal Hygiene. d other then event. The M		17. Father's Name (First, Middle, Last)	rive	r		18. Mothe	r's Name	(First, Middle	⊥Tax e, Maiden	_			
ä	d a b	To Be	James Meiklejohn				Lois	Mi11	er					
ary	s 1 and 2 should be f Heelth and Mental ftem 27 is marked of other treumetic eve	-		19b. Mailir	ng Address					ber, City	or Town, State, 2	Zip Code)		
	7.2 mg		Lois Meiklejohn / Mother 1	L77 🗚	cton	Road	An	mapo	lis, M	D 21	403			
J.	of Hee		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place cem	ce of Dispo netery, cren	sition (Nar natory or o	ne of ther plac	e)		ate	20c. Lo	ocation - City or	Town, State		
Ĕ	nit. Pages sartment of cortent: if It injury or o		`4 □Donation 5 □Other (Specify) Meado						2004	E1kr	idge, M	ary land		
Baltimore,	permit. Pages Department of I importent: if Its any injury or o		21. Signature of Fuperal S	- 1	2. Name an 47 Du			JO			or Fune:			
	Pnysician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulseas) or injury that initiated events C.	nce of):								Interval Bet Onset and I	ween Death	
D. Box 68760,	The law requires that the deeth certificate be executed the has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown Unknown Unknown Due to (or as a consequent of deat 2 Unknown ry eath 3□	⊒Ectopic pi						23d. Date of dei Month	-	Year		
ds, P.O	uires Ihat th signed by id be detacl	by	Part II. Other significant conditions contributing to death but not resulting	ng in the u	inderlying o	ause give	en in Part I		1		use contribute to	o the cause of d		
Records,	The law requir	Completed								s an opsy formed? 227 No	prior to death?	utopsy findings completion of c	available ause of	
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?			7		of Death	(Check only	one)				
of V	d is	ပို	1 ☐ Yes 2 No Hospital: Numpatient 2 ☐ EF	VOutpatier			4 🗀 140				6 ☐Other (Spe	cify)		
u	Jing P. After t funera	on:	Natural 5 □ Pending (Month, Day Yeer)	8b. Time o Injury		28c. Injun Worl			28d. Describe	now inju	ry occurred			
Division	To the Hospitei or Attending Ph within 24 hours after death. To the Funerei Director: After th completely filled in by the funeral	Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined							28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	urs afte	Cel				-100					\	a state of		
	To the Hospitel or Attendwithin 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowle and manner stated.		vestigation	n, in my o	pinion, dea			, date an	d place, and due	e to the cause(s)	
	To t To t	Σ	29b. Signature and tittle of certifier		29		5 (07		29d. Da	ite signed (Mont	rn, Dey, Year)		
			30. Name and address of person who completed cause of death (Item 2	:3a) (Type,	Print) 20					Anh	/23/0 apolis,	MD 214	01	
			31. Date filed (Month, Day, Year) 32. Registrar's Signatur	гө	A.	nne	H.		01 1	led	(car) (ou te.	r ·	
:	St Regist	ate rar	MAY 2.7 2004 Seek &	Book	a)									

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) Month Day **Physician** Josephine Katherine Paoletti Jun 6, 2004 2100 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner Allegany County Nursing Home Allegany Cumberland If Undar 1 Yaar If Under 24 Hrs. Months Days Hours Min. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Numbar 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 1□ M 2□X 214-05-7095 87 Jul 8, 1916 MD Director Usual Rasidence of Decedant 10c. City, Town or Location 10d. Insida City Limits 10b. Count itam 27 is marked other than "natural", or itama 23a or 28a-f show other traumetic event, the Modical Examinar must be notified at MD Allegany Cumberland 1 ☐ Yes 2 ☐ No Director 10g. Citizan of What Country? 10f. Zip Coda 10e. Street and Number 1813 Frederick St. 21502 USA Funeral within 72 hours after deeth 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Giva Yaar or Datas: 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 Never Marriad 2 Married other than "natural", or 1□Yes 2□XNo Specify: Specify: 2 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grada complated) Elemantary/Secondary (0-12) Collega (1-4or 5+) Glass Cutter Cumberland Glass Co. 18. Mother's Nama (First, Middla, Maiden Sumama) permit. Peges 1 and 2 should be fit.
Department of Heelith and Mentel Hy
important: If item 27 is marked othe 17. Fathar's Nama (First, Middla, Last) Orazio LaGratta Lena Serra LaGratta 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ann Paoletti daughter 3325 Summer Place Port Orchard WA 98366 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition
1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State Date 20c. Location - City or Town, Stata SS Peter Paul Cemetery 6/12/2004 Cumberland MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 23a. Part1. Emer the disease, or complice lons that cau ad the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Intarval Betwaen Onsat and Daath Physician Immediate Causa (Final disaase or condition rasulting in death) /Medical · CEREBROVASCULAR DAYS Examiner Due to (or as a consequence of) Examiner ed by the attending physicien end detached for use es the buriel-trensit Sequantially list conditions, if any, leading to immadiate causa. Entar Undarlying Cause (Diseasa or injury that initiated evants rasulting in death) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consequenca of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CARCINOMA δ After this certificate has been signe funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed performad' 1 □ Yes 2 □ No 1 Yes 2 LNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Othar: 45 Nursing Homa 5 Residance 6 Othar (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yaar) 28b. Time of 27. Manner of Death 5 ☐ Pending 1 Watural 1 ☐ Yas 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and place, end due to the cause(s) and manner es steted
2 Medical Examiner: On the basis of axaminetion and/or invastination in my opinion, doubt account of the cause(s) and manner es steted 29a, Certifier edicai

Division of Vital Records, P.O. Box 68760, within 24 hours efter deeth.

To the Funeral Director: After this completely filled in by the funeral of or A

Saltimore, Maryland 21215-0020

State Registrar

homo

30. Name and eddress of person who completed causa of death (Item 23a) (Type Print)

29b. Signatura and title of certifiar

Robustiano Barrera M.D. Mem. Hosp Med Bldg Cumberland MD 21502

1486

29d. Date signed (Month, Day, Year)

2004

Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29c. Licanse number

John 9

DHMH 16 Rev 6/95

04-03677 * RKD

		For Unpend Item #29 State Registrar 1. Decedent's Name (First, Middle, Last)		Cei	rtificate	e of L	Death			Reg. No.		3. Time of D	
Physicia /Medica		Tyler Francis F	arker						JUNE	Day	2004	3:50P.	М
Examine		4a. Facility Name (If not institution, give stree WASHINGTON ADVENTIST					Location o	of Death	40		4c. County of Death ONTGOMERY		
. Funeral Director		5. Social Security Number 6. Sex 1 M M	7. Age (In yrs.	last birthday) Yrs.	If Under Months 3		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 2-17-	y, Year)	Cou	place (State or F intry) ryland	oreig
ith the Maryland or 28a-f ehow e netified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arun		ty, Town or Lo	ewate							10d. Inside City 1 ☐ Yes 2	
with the or 2		10e. Street and Number 2117 Shore Drive			10f. Zip	Code 1037	,			10g. Citize	en of What Cou USA	intry?	
urs a	d by Funeral	11. Marital Status 1 XNever Married 2 Married	Vas Decedent Ever in U Armed Forces? ☐ Yes 2 X No f Yes, Give 'ear or Dates:			ent of Hi		gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		4. Race - Ameri Black, White		
filed within 72 hours Hygiene. ther then "neturel", ent, I're Medics! Ex.	Completed	0	nnpleted) College (1-4or 5+)	(Give	tent's Usual kind of work DO NDT use N/A	k done d e retired,	urina most	t of worki	ing	16b. Kind	d of Business/Ir	ndustry	
permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 le marked other the any injury or other treumetic event, ITE ONCE.	To Be (17. Father's Name (First, Middle, Last) Timothy Matthew					18. Mothe		e (First, Middle, Ly Ann			_	
and 2 sho salth and n 27 le ma er treume		19a. Informant's Name/Relationship (Type, I Timothy M. Parker/ F	,		g Address Shor				al Route Number ater, M		Town, State, Zij)37	o Code)	
Pages 1, nent of He int: If iten iry or oth		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)	val from State	Place of Dispo cemetery, cren akemont	natory or oth	her place	. 1	6-5-0	04		ation - City or T vidsonvi	own, State ille, MD)
permit. Departn Importa any inju		21. Signature of Funeral Service Licensee										cal Home 4D 21037	
Pnysician /Medical		23a. Part1. Enter the disease, or complicatic shock, or heart failure. List only one callmmediate Cause (Final disease or condition resulting in death)	ns that caused the deat use on each line. Sudden Infa			,		cardiac c	or respiratory ar	rest,		Approximate Interval Betwee Onset and Dea	
ate be executed thysician and the burial-transit	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):												
Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	by Physician/Medical	in the past 12 months?	yes, outcome of pregna □Live birth 2 □ Feta □ Pregnant at time of d □ Unknown	I death 3	Ectopic pre					23	d. Date of delive	ery Day Yea	r
w requires that the bear signed by should be detact	ed by Pr	Part II. Other significant conditions contribu	ting to death but not res	ulting in the ur	iderlying ca	usa give	n in Part I.			es 2 🗆		he cause of deat	
ician: The law recertificate has be rector, page 2 sho	Completed								24a. Was autop perfor	sy	prior to co death?	psy findings ava mpletion of caus 2 No	lable of
tending leath. tor: After the fune	25. Was case referred to medical examiner? 1 X Yes 2 No Hospital: 1 Inpatient 2 Xer/Outpatient 3 DOA Cother: 4 Nursing Home 5 Residence 6 27. Manner of Death Norwing Home 5 Residence 6 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 Yes 2 No 28d. Describe how injury (Month, Day Year) 28d. Describe how injury (Month, Day Year) 28d. Describe how injury (Month, Day Year) 28d. Location (Street and City or Town, State)								ence 6 [ow injury o	occurred			
or At													
To the Hospitel within 24 hours a To the Funerel Completely filled	Medical	(Check only 2X Medical Examiner:	On the basis of examina and manner stated.	ition and/or inv	estigation, i	in my opi	nion, death	h occurre	ad at the time, o	late and pl	lace, and due to	the cause(s)	
Within To the comp	Σ	29b. Signature and title of certifier	1 10-			License					signed (Month,	Day, Year)	
		30. Name and address of person who comple	a L ACT led cause of death (Item	n 23a) (Type, I	Print)		M.E.	L F			2,2004	2120*	
	e	31. Date filed (Month, Bay Year) JUN 1 0 200	32. Registrar's Signa	1	тт ье	aul S	rree	L, Bi	altimor	e, Ma	ryland	21201	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2^{Day} 2004 May 8:55p M Marion M. Rehbein /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Hospital Bel Air Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 076-09-2910 1 □ M 2 X F 89 Yrs. Director New York Sept. 11, 1914 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Harford 1 ☐ Yes 2 ☑ No MD Bel Air Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 Sunflower Drive Apt. 275 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🐼 No If Yes, Give Year or Dates: 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 X Widowed 4 □ Divorced "neturel", leted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Compl Elementary/Secondary (0-12) College (1-4or 5+) Licensed Practical Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental and Mental Robert K. Mules Nora L. Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica Butz/Daughter 1303 Marquis Court Fallston, MD 21047 Health item 27 | 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 27, Department of H Importent: If ite eny injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 2004 Glen Burnie, MD * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Barranco & Sons, 21. Signature of Funeral Service, License P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 Pa. . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Immediate Cause (Final YU CUNU Physician disease or condition sulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury death certificate be executed use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐ Pregnant at time of death 5 ☐ Other (specify) No 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 2 No 3 Probably 4 Unknown 1 Tes Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2/5 Yes Be 25. Was case referred to medical 26. Place of Death (Check only on Other: 24 No 1 🗌 Yes 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred deh bein, Hospitel or Attending Natural Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after deat To the Funerel Director; 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29b. Signature and title of ceptities 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAL Air Muni MASW

Registrar

DHMH 17 Rev 1/20/01

State of Maryland / Department of Health and Mental Hygiene 2001

				Oldio oi iii	y	Cert	ificate of	Death		Reg. No.	14 18432
	Division		1. Decedent's Name (First, Middle, Las	it)					2. Dete of De	eth Day Ye	3. Time of Death
	Physicia /Medica		Hazel Emma Ray					May	8 20	2047:41 pm	
. /	Examine		4e Fecility Neme (If not institution, give 8917 Hazel Lane	street and number)			4b. City, Town, or L Hancock	/	4c. County of D Washin		
	Funeral Director		213-36-3984	ex 7. Age □M 2 🟋 F	e (In yrs. lest 89	Van	If Under 1 Year Months Days		8. Date of Bird (Month, Da July 8	th y, Yeer) , 1914	Birthplace (Stete or Foreign Country) MD
	pu *	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d.									
	Maryle	ctor	MD Washington Hancock 1□Yes								
	uth with the Marylen 23e or 28e-f show	ai Director	10e. Street end Number 8917 Hazel Lane			10g. Citizen of What USA	Country?				
)20	Ar items	by Funeral	11. Maritel Stetus 1 Never Married 2 Married 3 🖫 Widowed 4 Divorced	12. Wes Decedent I Armed Forces? 1 ☐ Yes 2 X I If Yes, Give Year or Dates:	·		21750 as Decedent of I res, specify Cub Tyes 257 No	Hispanic Origin? (Sp an, Mexican, Puerto Specity:	pecify Yes or No Ricen, etc.)		omerican Indian, White, etc. White
9	2 hou	8	15. Decedent's Ed	15. Decedent's Education			nt's Usual Occu	petion		16b. Kind of Busine	
Maryland 21215-0020	within ene.	Completed	(Specify only highest grader) Elementary/Secondary (0-12)	de completed) College (1-4or 5		Give ki life. DC Seamst		during most of world)		Clothing	Manufacture
d 2	年工を置		17. Father's Neme (First, Middle, Last)			Deams (ress	18. Mother's Nam		Maiden Surname)	nanuracture
/lan		To Be	Samuel Hull					Kate D	ickerhof	f	
lan	2 should end Men is marke sumatic		19a. Informant's Name/Relationship (7	ype, Print)	1	19b. Mailing	Address (Street	t and Number or Ru	re/ Route Numbe	er, City or Town, Stat	e, Zip Code)
≥,	ealth n 27		Carolyn Keefer/Da	ughter						rs, WV 25	
Baltimore,	Peges 1 nent of H nt: If Itan iry or oth		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □	Removal from State			tion (Name of tory or other ple		Date	20c. Location - City	
Itim	bemit. Peg Department mportant: I Iny Injury c		4 ☐ Donetion 5 ☐ Other (Specify		Orcha		dge Cem		05/12/04]	Hancock, M	D
Ba	Depa Impo any ir	1	21. ignature of uneral	**************************************				,		l West Mai	in Street 21750-0368
	1126		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	ofications of the crused	the death. D						Approximete Interval Between
	Physician		shook, or real tallure. List only t	1/1	1.	1	120	-1			Onset and Death
1	/Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)	e. Alk	elul	14	Dull	ella	1		10 Tears
		Jer	1650king in Goduly	Ath	Pue to (or as	a-conseque	ence of):	GiTonia	hea	116	
	rificete be executed ng physiclen end es the buriel-trensit	Examiner	Sequentially list conditions,	Due to (or es e consequence of):							
60,	be ex	9 E	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury	c	Gler	d				/	10 fears
68760,	ng phys es the	edical	that initieted events resulting in death) Last		Due to (or as	e conseque	nce of):				
Box		Σ		d							
	0 0 0	31018	Pert II. Other significant conditions co	ontributing to death bu	ut not resultin	g in the und	erlying cause gi	ven in Part I.	23b. Did t	obacco use contrib	ute to the cause of death?
P.0	requires that the de peen signed by the e hould be deteched t	Physician	Myneiteus	con					1 🗆 1	Yes 20 No 3	Probably 4 Unknown
ds,	signe d be c	S C	A	- mall A	1				24a Was	an eutopsy 24	b. Were autopsy findings
of Vital Records,	lew requires been si a 2 should	Completed	money	Mellell	5				perfo	rmed?	available prior to completion of cause of death?
Re	The lew ate hes page 2	E							101	es 2 10 No	1 ☐ Yes 2 ☐ No
ita	certificate rector, par	e C	25. Was cese referred to medical					26. Place of Dea	th (Check only o	ne)	
25. Was cese referred to medical examiner? 1 yes 2 27 No 25. Wenner of Death (Chec. 1 Inputient 2 ER/Outpatient 3 DoA Other: 4 Nursing Home 5 St. 27. Wenner of Death 28b. Date of Injury 28b. Time of 28c. Injury at 28b. December 28b. Time of 28c. Injury at 28b. December 28b. Time of 28c. Injury at 28b. December 28b. Time of 28c. Injury at 28b. December 28b. Time of 28c. Injury at 28b. December 28b. Time of 28c. Injury at 28b. Time of 28c. Time of 28									ome 5 Hesio	lence 6 Other (S	ipecify)
o u	ding Ph h. After th funeral		27. Menner of Beath 1 ☐ Neturel 5 ☐ Pending	28e. Date of Injur (Month, De)	Year) 28	b. Time of Injury	28c. Inju Wo M 1	ryat irk?]Yes 2 □ No	28d. Describe h	now injury occurred	
Division	Attanding or death. actor: After by the fune	Car	2 Accident investigation 3 Suicide 6 Could not be		ırv - At home	farm. stree] 162 Z [NO	28f. Location /S	Street and Number or	r Rural Route Number
Θ	offer death	Certification:	4 ☐ Hornicide determined	building, etc	. (Specity)	, , , , , , , , , , , , , , , , , , , ,	, .aa.a, ,a		City or Tow		
		edical C		ysician: To the best of liner: On the basis of and manner ste	exemination						
	within 2 To the comple	Ø ∑	29b. Signature end title of certifier	And mariner ste			29c, Licens	se number		29d. Date signed (Mo	onth, Day, Year)
	F ₹ F ö		SAMUEL (1	1 AN, MA			1) 3	6655	1	MASS IV	7004
	11	-	30, Name end eddress of person who o	completed cause of de	eath (Item 23	e) (Type_Pr	int)		111-	1971	5 2.1
	7		30,4 East A	NTIETAM,	er's Signature	rees	dull	200.	Traggers	town, m	0 1140
E	State Registra	97	JUN 1 0 2004	Eur	4	9 4	parks	,		,	

DOS

DOS
04-3685
Jeanne Harper Ramsbottom
For State of Maryland / Department of Health and Mental Hygiene? 101.22

			1 - State Registrar	Certific	cate of Dea	ath.	Reg. No.	10433
14.4	Dhusisi	· .	1. Decedent's Name (First, Middle, Last)			2. Date of Dea	ath	3. Time of Death
	Physici Medio/		-Jean Prosser Ramsbottom	Jeanne Harper	Ransbottan			0055 a ^M
	Examin		4a. Facility Name (If not institution, give street and number) Memorial Hospital	4b.	City, Town, or Local Cumberlar	tion of Death	4c. County of Death Allegany	1 0000
	uneral irector		030-44-3587		Inder 1 Year If Unths Days Ho	order 24 Hrs. ar. Min. 8. Date of Birth (Month, Day 4-15-15)	v. Year) Coun	lace (State or Foreign ttry)
	how		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Location	1		1	Od. Inside City Limits
ле Мат	8a-1s	Director	WV Mineral	Fort Ashby				1 ☐ Yes 2 X No
with t	s or 2	Dir	10e. Street and Number		f. Zip Code		10g. Citizen of What Coun	try?
death	ms 20	Funeral	Country Villa Apartments, Apt. 11. Marital Status 12. Was Decedent Ever in Armed Forces?		26719 Decedent of Hispani	C Origin? (Specify Yes or No- xican, Puerto Rican, etc.)	USA 14. Race - America	
Ind 21215-0036 be filed within 72 hours after death with the Maryland tal Hygiene.	ral, or items 23a or 28a-f show Examinat inval be redified at	5	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		es 2 ¹ No <i>Spe</i>		Specify:	
15-0	r than "natu The Medical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give kind o	Usual Occupation of work done during OT use retired)	most of working	16b. Kind of Business/Ind	lustry
212 d withii	Than Than	omp	Elementary/Secondary (0-12) Coilege (1-4or 5+)		omemaker		Own Home	
nd h	d other	Be C	17. Father's Name (First, Middle, Last)			lother's Name (First, Middle,		
Maryland d 2 should be file th and Mental Hy	Is marked of reumatic ever	2	Robert M. Ramsbottom			arol (Durfee)		
Mal Id 2 st	item 27 is marked othe other treumatic event,		19a. Informant's Name/Relationship (Type, Print) Carol Levy/mother			umber or Rural Route Number ts. #113, Fort		
or teal	item 27 l other tre		20a. Method of Disposition 20b	D. Place of Disposition cemetery, crematory	(Name of	Date	20c. Location - City or Tox	
altimore,	ent: If ury or		1 ☐ Burial 2 🛎 Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify)	carpelli Fune	ral Home, P.		Cresaptown, M	
Balt permit. Depart	Importent: If ite any injury or of once.		21. Signature of Funeral Service Licensee	22. Nam Shaff	e and Address of Fer-Warnick	acility Scarpelli Fun Funeral Home, 230	neral Home, PA: Main St. Romo	for ey, W ₂₆₇₅₇
			23a. Part1. Efter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.	eath. Do not enter the	mode of dying, suc	n as cardiac or respiratory arr	est,	Approximate Interval Between
/M	sician edical miner		Immediate dause (Final disease or condition resulting in death) Multiple injuing in death) Due to (or as a consistency of the conditions, b.		ated by nan	cotic and alcohol	intoxication	Onset and Death
K 68760, ertificate be executed	ician and burial-transit	ai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons				•	
vision of Vital Records, P.O. Box 687 Attending Physician: The law requires that the death certificate r death.	signed by the attending physician and I be detached for use as the burial-transit	Physician/Medical	d	etal death 3 Ectop	oic pregnancy r (specify)		23d. Date of deliver Month	y Day Year
rds, P	. 0	þ	Part II. Other significant conditions contributing to death but not r	esulting in the underlyi	ing cause given in P		bacco use contribute to the	
Division of Vital Records, or Attending Physician: The law requires to after death.	SC	Completed				24a. Was a autops perform	y prior to com ned? death?	sy findings available pletion of cause of
/ita	certificate rector, pag	Be	25. Was case referred to medical examiner?		26. P	lace of Death Check onl on		
Of Physi	r this or	. To				Nursing Home 5 Reside	ence 6 Other (Specify)	
sion anding	or: After	ation	1 □ Natural 5 □ Pending 2 □ Accident investigation	founding p	28c. injury at Work?		w injury occurred	
o o a	To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Spe	t home, farm, street, fa	ctory, office	City or Town	reet and Number or Rural n, State) fineral County,V	
To the Hospital	he Funei pletely filt	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, death occur ination and/or investiga	rred at the time, date ation, in my opinion,	e and place, and due to the ca death occurred at the time, da	luse(s) and manner as state ate and place, and due to t	ted. the cause(s)
Tota	Tot	W	29b. Signature and title of certifier		29c. License numb	er 2	9d. Date signed (Month, Da June 3, 200	
			30. Name and address of person who completed cause of death (It	lem 23a) (Type, Print)	lll Penn S	Street, Baltin	ore, Marylan	nd 21201
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signary 1 1 2001	inature	Anage 3	ve .		

State of Maryland / Department of Health and Mental Hygiene? [] [] [] 18434 Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 Month MAY Yeer **Physician** 21, 4:15 PM OLLIE JORDAN SMITH /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CARROLL WESTMINSTER 323 HOOK ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 1 F 30, 1924 FLORIDA 80 Director 255-28-3090 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Items 23a or 28a-f show the Medical Examiner roust by notified at 1 □ Yes 2 100 DEKALB Director ATLANTA **GEORGIA** the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES 30329 1893 BRUCE ROAD death Funerai 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★★0 If Yes, Give permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or itementy injury or other traumatic event, the Medical Examinist ODEs. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specity. Specify: WHITE Completed by 3 ☐ Widowed 4√Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) ACCOUNTING CLERK LIFE INSURANCE CO. 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be IDA MAY BELCHER OTIS NESBIT JORDAN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 323 HOOK ROAD, WESTMINSTER, MD 21157 SANDRA I. CUSHEN, DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 5/24/2004 CARROLL CREMATION HAMPSTEAD, MARYLAND 21. Signature of Funeral Service License MYERS-DURBORAW FUNERAL HOME, P.A. Luca 12 Hakett 91 WILLTS STREET, WESTMINSTER, MD 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause opposit line. Approximate Internal Between Onet and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a con eque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FÉMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 DUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by been signe should be 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No page 2 certificate 1 Yes Division of Vital To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) DAVGHTER'S Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 27. Man of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death 2 Accident Director 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 4 Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check or one) 29c. License number nd title of certifier 29b. Signatu Street Westwester, completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Yeer) State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2 0 0 4 Certificate of Death 2. Oate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 0201 AM **Physician** Malcolm James Slebzak 64 05 22 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PENINSUIA REGIONAL MEDICAL CENTER SALISBUY4 HICOMICE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□F 213-14-5958 80 NY **Director** Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at DE Sussex Millsboro 1 ☐Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19966 80 Starboard Avenue, G13 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is markad other than College (1-4or 5+) Elementary/Secondary (0-12) Supervisor/Manufacturing Eng. Westinghouse land 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen (Unknown) John Slebzak Maryl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tran 80 Starboard Avenue, G13, Millsboror, DE 19966 Dorothy F. Slebzak/Wife May 27, 2004 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State Crownsville, MD Veterans Cemetery * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 7495 Gov. Ritchie Hwy, Severna Park, MD 21146 495 Gov. Ritchie Hwy, Severna Park, MD Part1. Enter the disease, or complicate shock, or heart failure. List only one complicate dications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Interetion **Physician** Myocerdial Acute /Medical Examiner ASCAD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the as attending USB 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time ol death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year ō Day 5 Other (specify) signed by the at d be detached for o. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à 1 Yes 2 ₹No 3 Probably 4 Unknown Completed been 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page certificate 2 10 1 Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 1 Yes 2 4No this 28a. Date of Injury (Month, Day Year) To the Funeral Director: After the completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: Injury Division 1 Alatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 \(\text{Homicide} \) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier D02038 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bluff Road Salisbury Michael 201 / ar's Signature 2004 Regi 31. Date liled (Month, Day, Year) **MAY** 2

DHMH 17 Rev 1/2001

State Registrar

COLM

			1 - For State Registrar	State of Maryl	and / Dep	artment of F	lealth and	Mental Hy	Reg. No.	04 18436
**	Physici /Medic		Decedent's Name (First, Middle, Last) MARY FLORENCE	SMYER					22, 2004	3. Time of Death 11:45 A ^M
	Examir Funeral	er ,	4a. Facility Name (If not institution, give s GINGER COVE NURSI 5. Social Security Number 6. Sex	NG HOME 7. Age (In	yrs. last birthday) Yrs.	ANNAP(If Under 1 Year Months Days		8. Date of Birt	h y, Year)	ARUNDEL 9. Birthplace (State or Foreign Country)
	Director work and anything and anything anythin	ctor	223-40-8892 Usual Residence of Decedent 10a. State 10b. County MARYLAND ANNE ARUI	100	City, Town or Lo			JUNE 14	4, 1920	ALABAMA 10d. Inside City Limits 1 ↑ Yes 2 No
960	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene item 27 is marked other than "natural", or Items 23a or 28a-1 ahow other traumatic event, the Medical Every per market	I by Funeral Director	1203 RIVER CRESCEN' 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	I DRIVE 12. Was Decedent Ever Armed Forces? 1		10f. Zip Code 21401 Was Decedent of Hill Yes, specify Cuba 1 □ Yes 2☒ No	lispanic Origin? (S an, Mexican, Puerl Specify:		U.S.A. 14. Race- Black, Specify:	•
21215-0036	ed within 72 hoygiene. ygiene. her than "natuit, the Mudical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo d) ACHER		EDUCATI	CON
Maryland	should be filed ind Mental Hygi s marked other umatic event, I	To Be	17. Father's Name (First, Middle, Last) CHARLES COOPER	ROBERTS	10h Maili	ng Address (Street	MARY	EMMA S	Maiden Sumame) SPEAR	
Baltimore, Ma	permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum <u>once</u> .		19a. Informant's Name/Relationship (Ty) JANICE MILAZZO/DAU 20a. Method of Disposition 1	GHTER emoval from State	403 B Db. Place of Disportentery, cre HUNTT CR.	UCKSPUR (psition (Name of matory or other place	COURT MI	LLERSVII Date 4/2004 THE ROBEI	LLE, MARY 20c. Location - C WALDORF RT E. EVA	TLAND 21108 ity or Town, State MARYLAND NS FUNERAL HOM
8760,	ate be executed /Medical Examiner /Medical and /Medical the burishtransit	dicai Examiner	23a. Part1. Enter the disease, or complishook, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to animediate cause. Enter Underlying Cause (Disease or injury that infittated events resulting in death) Last	Due to (or as a cor	ARREST Insequence of): LEROTIC Insequence of): SION	ter the mode of dyir			rest,	Approximate Interval Between Onset and Death
.O. Box 68	The law requires that the death certilica ate has been signed by the attending phagge 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of print 1 Live birth 2 Liv	Fetal death 3	Ectopic pregnancy Other (specify)	/		23d. Date Month	, ,
<u> </u>	quires that n signed build be deta	by	Part II. Other significant conditions con DEMENTIA	tributing to death but no	t resulting in the u	nderlying cause giv	en in Part I.		37	ute to the cause of death?
Vital Records,		Completed	DIABETES					1 Yes	sy primed? dec 2X No 1	ere autopsy findings available or to completion of cause of ath?] Yes 2뛏 No
Division of Vit	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatient 28a. Date of Injury (Month, Day Yea 28e. Place of Injury - building, etc. (Sp	At home, farm, st	f 28c. injur Wor M 1 🗆	er: 4X Nursing H	28d. Describe h	lence 6 Other	
	Hospital of the same of the sa	Medical Ce		sician: To the best of my ner: On the basis of exal and manner stated.						
t	To the within To the comple	Me	29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who co	resson	(Item 3a) (Type	29c. Licens D025			29d. Date signed (5-23-20	*
	Sta	ate	CAROL PRESSEY, MD	, 104 RIDGE	LY AVE.,	#201, AN	NAPOLIS,	MARYLAN	D 21401	
	Regist	rar	MAY 25	2004	w so	4				

			1 icuse	State of Marylar						-	_	10107
			1 - For State Registrar	Otate of Marytar			e of D				a. No.	4 18437
			Decedent's Name (First, Middle, Last	()					2.	Oate of Deat	h Day Year	3. Time of Death
	Physici /Medio		Kirk L. Turi	ner					M	ay 14		9:10 p M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or L	ocation of	Death		4c. County of Oe	eth
1			Genesis Elder Ca	are Spa Cres	le at historical	Ann If Under	ano1	i S If Under 24	4 Hrs p	Date of Birth	Anne Ar	undel
D.	Funeral Director			7. Age (In yrs.	Yrs.	Months	Days	Hours	Min.	(Month, Day,		irthplece (State or Foreign Country) [arvland
			220-84-6786 Usuel Residence of Decedent	43					IN	00. 2	Z 1900 M	
	ryland	_	10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits T☐Yes 2 ☐ No
	Ba-f e	Directo	Maryland Anne A	cundel Ann	apoli						0 - 0112	
	death with the Maryland ims 23a or 28a-f ehow f must be notified at		10e. Street and Number			10f. Zip				"	og. Citizen of What (
	ns 23	Funeral	603 Wye Island 11. Marital Status	12. Was Decedent Ever in U	l.S. 13.		401 dent of Hisp	panic Origi	in? (Specif	y Yes or No-	USA 14. Race - An	nerican Indian,
മ	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "naturel", or Itams 23s or 28s-1 show event, the Medical Examiner must be notified at		Named 2 Marned	Amed Forces? 1 ☐ Yes 2 ☑ No		If Yes, spec 1 ☐ Yes			Puerto Ric	an, etc.)	Black, Wh	ite, etc. Black
9	within 72 hours after ene. then "naturel", or Ite he Medical Examine	1 by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 105	25,7500	Specify:				
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Q	Hygid other	Be Co	17. Father's Name (First, Middle, Last)	U	1	пало		8. Mother	's Name (F		Maiden Surname)	toyed
lan	should be nd Mental marked o	To B	Lawrence Tu	cner				A1	ice	Hunt		
Maryland 21215-0036	~ 20 2		19a. Informant's Name/Relationship (City or Town, State,	
	permit. Pages 1 and 2 Department of Heath s important: if item 27 ti eny injury or other tre 9008.			ther)		-					lis, Md.	
Baltimore,	ges 1 It of H If ite or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State H1	Place of Dispo cemetery, creating II Cr irdens	matory or o	ther place) Memo	rial	Date		•	
ΙĖΪ	it. Pa irtmen irtant: njury		4 □ Donation 5 □ Other (Specify21. Signature of Funeral Service Licen) Ga	rdens	Name an	nd Address	of Facility	/20/	04	Annapol	is, Md.
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			23a. Part1. Enter the disease, or compshock, or heart failure. List only	olications that caused the dea	th. Do not en	ter the mod	le of dying,	such as ca	ardiac or re	DOLIS espiratory arre	st, MO · ZI	Approximate Interval Between
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Box	eath certif attending for use as	lan/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 Live birth 2 Fets	al death 3	Ectopic pr					23d. Date of d Month	elivery Day Year
<u>o</u> .	he de the a	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of o	seath 5	Other (sp	ж спу)					
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Records	quires thain signed I	ed by								1 ☐ Ye	s 2010 3 1	Probably 4 Unknown
900	aw requir 1s been s 2 should	Completed								24a. Was an		autopsy findings available comptetion of cause of
Ě	The ate h page	Com								perform		
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of	Physician: this certific ral director,	. To	1 Yes 2 No	Hospital: 1 Inpatient 2 Inpatient 2 Inpatient 2	ER/Outpatier 28b. Time o	_	OA Other: 28c. Injury a	4 / Nurs			nce 6 Other (Sp w injury occurred	ecify)
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Division	If or Attending after death. I Director: Afte d in by the fune	Iffica	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, st	reet, factory	y, office		28f	Location (Str City or Town	reet and Number or I	Rural Route Number,
á	s after s after Direction belon Certification;	4 Homicide	building, etc. (Speci	·y)					City of Town	, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical Exam	ysician: To the best of my knowner: On the basis of examina								
	To the h within 24 To the F complete	Medi	29b. Signature and titte of certifier	and manner stated.			c License i	number		29	9d. Date signed (Mor	nth. Dav. Year)
)	M C O		S. Signature and the or certified	Emino		250)	7.20	36		S/IP/	10
			30. Name and address of person who	mpleted cause of death (Ite	m 23a) (Type.	Print)	-				0,	/
			Gory 5 So	rose 24	U gc	i Dun	wh	Drive	CU	buter	Slipli MD216	(9
-53	Sta		31. Date filed (Month, Day, Year) ANY 25	32. Regierar's Sign	ature	Kan	M o					/
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ORIGINAL

				State of Maryland / Department of Health and M	ental Hyg	iene	
				1 - State Registrar Certificate of Death		eg. No 200	
		Physici		1. Decedent's Name (First, Middle, Last) Lillian Elizabeth Valenta	2. Date of Deat Month	Day Y	3. Time of Death
		/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	JUNE	4c. County of I	
	1			Upper Chesapeake Medical Center Bel Air		Hari	
		Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Another Security Number 216–24–8687 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, June 3,	1928	Birthplace (State or Foreign Country) Maryland
,		_		Usual Residence of Decedent			10d. Inside City Limits
3		sth with the Marylar 23a or 28a-f show	or	10a. State 10b. County 10c. City, Town or Location MD Harford Belcamp	,		1 ☐ Yes 2√ No
0		or 28a-	Funeral Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of Wha	it Country?
0		s 23a c	raiD	1301 Sandwort Ct. Apt. 102 21017	* Y	U.S.A.	A
	10	fter de r Items ilner n	Fune	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 XNo	Rican, etc.)	Black, \	American Indian, White, etc.
	903	ours a iral', o	b	3 ② Widowed 4 □ Divorced If Yes, Give Year or Dates:		Specify: V	Vhite
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00	pur	s 1 and 2 should be filed within 72 hours after death with the Maryland f Heath and Mental Hygiene. I heath and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be mutified at	Be (17. Father's Name (First, Middle, Last) Clarence Giles Anna	(First, Middle, I Krieder	Maiden Sumame)	
oc t	Maryland	should nd Mei marki	T _o	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura		, City or Town, Sta	ite, Zip Code)
		s 1 and 2 of Health a item 27 le		June E. Caraulia (daughter) 1301 Sandwort Ct. Apt		Belcamp,	
32	Baltimore,	ages 1 nt of H :: If ite		20a. Method of Disposition 1 Burial 2 The Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) R. A. Ferris & Co, Inc.	04	20c. Location - Cit West Ches	
	altin	permit. Pages Department of Himportant: If ite any Injury or of once.					ocer, in
	ä			21. Signature of Princial Service Licensee 22. Name and Address of Facility Tarring-Cargo Funer Aberdeen, Maryland	21001=	3359 ^A •	
				23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac coshock, or heart failure. List only one cause on each line.	or respiratory arr	est,	Approximate Interval Between Onset and Death
		Physician /Medical	П	Immediate Cause (Final disease or condition resulting in death) a. Hyps Glycemia Jatrosehic Due to (of as a consequence of):		·	
-		Examiner		Braleic Bings			2 Days
0	<u> </u>) bed used	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C. Due to (or as a consequence of): C. C. C. C. C. C. C. C. C. C. C. C. C. C			2000
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	68760,	cate be exphysician	dicai	d			
	Box 6	leath certificate attending physi	n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date o	f delivery
	O. B	The law requires that the death certifica ite has been signed by the attending ph bage 2 should be detached for use as th	Completed by Physician/Med	in the past 12 months? 1		Month	Day Year
7)	0	that the de led by the a detached f	/ Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tot	bacco use contribu	ite to the cause of death?
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llian	eco	b law re has be	nplet	Cere provasquar Accident	24a. Was a autops	y prior	re autopsy findings available r to completion of cause of
	al B			25. Was case referred to medical 26. Place of Death		2 No 1 🗆	Yes 2□ No
7	f Vital	S S T	To Be	examiner? Hospital: 3.		ence 6 Other (Specify)
3	0 0	ding Phys. After thi funeral		Natural 5 Pending (Month, Day Year) Injury Work?	28d. Describe ho	ow injury occurred	
cinta	Division	at at	ficat	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office			or Rural Route Number,
<u> 2</u>	ō	ital or its after all Direction belon to	Certification:	4 Hornicide Building, etc. (Specify)	City or Town	,	
B		To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	ledical	29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.	and due to the ca ed at the time, d	ause(s) and manne ate and place, and	er as stated. due to the cause(s)
		To the within To the comple	Me	29b. Signature and title of certifier 29c. License number	2	9d. Date signed (M	Month, Day, Year)
				Mario Hames D40819	- <	Tune 1,	2004
		H		30. Name and address of person with completed cause of death (Item 23a) (Type, Print) Marco Zamora 500 Upper Chesapeake Dr. Bel Air,	MD 210	14	
			ate	31. Date filed (Month, Day, Year) 32. Regierar's Signature			
		Regist	rar	JUN 3 2004 Steen & Sports			

		Tor State Registrar	State of Man	/land / De	partm		ealth an	d Mental Hy	/gier	ne 0	04	18439
Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last Elizabeth 4a. Facility Name (If not institution, give	Ann street and number)		4b. C		Location of D	2. Date of D May 23	3, 2		Year y of Death	
Funeral Director		Usuel Residence of Decedent	ex 7. Age (li	n yrs. last birthd 76 Yrs	ay) If Ur Mont	rederi der1 Year hs Days	If Under 24 I	Hrs. 8. Date of Bin (Month D)	irth lay, Yaa		9. Binh Wash	ick place (State or Foreign nty) iington,DC
uth with the Marylar 23a or 28e-f show ust be notified at	Funeral Director	Maryland Frederic 10e. Street and Number 131 Cody Drive #2	ck 1	ic. City, Town or	;	Zip Code			_	Citizen of USA	Whet Cou	10d. Inside City Limits † TYPES 2 □ No ntry?
er dez Items	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Decedent Eve Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	r in U.S. 1				(Specify Yes or Nuerto Rican, etc.)		14. Ra Bla	ce - Ameri ick, White	
Maryland 21215-0036 td 2 should be filed within 72 hours aft th and Mental Hygiene. 27 Is marked other than "natural", or traumatic event, the Medical Exami	Be Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+) 2	(G life	cedent's live kind of e. DO NO		uring most of		C	hurc		ndustry
ore, Maryland 2: 11 and 2 should be filed v 11 and 12 should be filed v 11 Health and Mental Hygie 11em 27 Is marked other t other traumatic event, th	To Be	17. Father's Name (First, Middle, Last) Norwood P. 19a. Informant's Name/Relationship (7) Christine A. Joya		19b. Ma 102	ailing Addr Emmí	ess <i>(Street</i> a	Mar nd Number or	Name (First, Middle Y Rural Route Numb Thurmont,	per, City	Coa or Town	tes , State, Zij	o Code)
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If tiem 27 1 any injury or other tra		20a. Method of Disposition 1 Rurial 2 Cremation 3 C 4 Donation 5 Other (Specify	Removal from State	Ob. Place of Dis	sposition (crematory Heav	Vame of or other place	5/:	Date	20c. Sil	Location Ver	- City or T	own, State
Ba Permi Depa Impo		23a. Pkri Wader the disease or companion, or heart failure. List only	dications that caused the	death. Do not	104	E. Mai	n Stre	et, Thurm	ont			
76 te be tysicia ne bur	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a co	nsequence of):	6 /	Verv	112					Years
h.C. BOX 68 that the death certificat ed by the attending phy detached for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant al time 9 ☐ Unknown	Fetal death	3 □Ectopia 5 □ Other	pregnancy (specify)					te of delive	ery Day Year
COTGS, P.O. w requires that the been signed by the should be detached.	leted by P	Part II. Other significant conditions of	1	ot resulting in the	underlyin	g cause give	n in Part I.	23e. Did t	Yes }	24h)	3 Prob	ney findings evallable
/Ita	Be	25. Was case referred to medical examiner?	La cariba la					- autor	psy prmed?		prior to codeath?	mpletion of cause of
on of ding Phy After this funeral d	Medical Certification; To	27. Manner of Death 1	28a. Date of Injury (Month, Day Ye	At home, farm,	of M	28c. Injury Work 1 [] Y	4 De Nursing	28d. Describe 28f. Location (: City or Tou	how inju	nd Numb	red	r) I Route Number,
DIVISIC To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier	rsician: To the best of miner: On the basis of exa and manner stated.	y knowledge, de mination and/or	investigati	on, in my opi !9c. License	nion, death oc	curred at the time,	date an	d place, a	and due to	ated. the cause(s) Day, Year)
) D		30. Name and oddress of person who on Dr. Gene Ashe 31. Date filed (Month, Day, Year)	ompleted cause of death 10200 Copp	ermine				MD 21798				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2004 Month MAY **Physician** HARRY LAWRENCE WHITEHEAD 25, 9:15 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1365 UNIONTOWN RD. CARROLL WESTMINSTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 / 4 / 1923 Birthplace (State or Foreign Country) **Funeral** Days Hours 1**½** M 2 □ F Yrs 215-12-7350 81 MARYLAND Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28e-f show MD. CARROLL WESTMINSTER 1 ☐ Yes 2X No Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 1365 UNIONTOWN RD. 21158 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritat Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner of Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1X Yes 2 □ No tf Yes, Give Year or Dates: WW II Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2X No Specify: Specify: ģ 3 Widowed 4 Divorced WHITE "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BUILDER CONSTRUCTION 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental Pages 1 and 2 should be ELERY WHITEHEAD PEARL KRICKBAUM 7 is marked treumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other treuonce. 1365 UNIONTOWN RD., WESTMINSTER, MD. 21158 VIRGINIA WHITEHEAD - WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State *4 □ Donation 5 □ Other (Specify) LORRAINE PARK CEM. 5/29/04 BALTIMORE, MD. 21. signature of 5 cc ral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Intervat Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** 3LADDER 6 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner physician and s the burial-transit The faw requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the at a be detached for Ö 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, INFECTION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown CANCER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 s autopsy performed? COROMARY DISEASE AR JERZY 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home Sesidence 6 | Other (Specify) 1 ☐ Yes 2 No Medical Certification; To s after death.

I Director: After this of in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🔲 Suicide Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital of within 24 hours aff To the Funeral Discompletely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ATTENDING D21155 MAY 27, 2004 iriva (ien) PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 904 WASHINGTON FOAD WESTINGTER ARTHUR L RUDO. M 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2001

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						Cei	tificate d	of Death		Reg. No.	J U 4	10441
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			Charles County N	ursing Hor	ne			La Plata		Cha	rles	
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	Director		214-32-9028 Usuel Residence of Decedent	X.	86	115.			JAN /	1910	Mary1	and
	pue &	-	10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits
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0	or its	2	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☑			□ Yes 25		ono mican, etc.)			
90	Int.	5	3X Widowed 4 □ Divorced	Year or Dates:				ao aposity.		Specif	y Whi	.te
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by tha funeral		one) 29b. Signature and title of certifier	and manner sta	ileti.		29c. Lice	ense number		29d. Date signe	d (Month 1	Day, Yeer)
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		-	20 Name and address of account	completed sever of d	ooth /ltc-	22a\ /T *						
0	np 10		30. Name end address of person who a Ashvin J. Patel,					Naldore	MD 2064	12		
1	Stat	e	31. Date filed (Month, Day) (Par)	200 32. Regum	er's Signatu	TTOIL C	#1U2	_ MaidOff	, איזה איז	14		
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		1 - For State Registrar	State of Maryland / Dep		Mental Hygie	•	1844
/M	sician edical iminer	1. Decedent's Name (First, Middle, Last, Robert 4a. Facility Name (If not institution, give Crofton Convalesce)	Alexander street and number) ent Center	Warren 4b. City, Town, or Location of Death Crofton		2004 4c. County of Death Anne Arus	3. Time of Death 6:35 P M
Fune Direc		5. Social Security Number 6. Set 578-42-3057 Usual Residence of Decedent	7. Age (In yrs. last birthday, Yrs. 96	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	year) 9. Birthpl County 1907 New Y	ace (State or Foreign try) Ork
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or Itame 23s or 28s-1 show any nitury or other traumatic event the Medical Engine and the Author as	To Be Completed by Funeral Director	10a. State Maryland Prince G 10e. Street and Number 12211 Raritan Land 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, Last)	200. Place of Disp.	10f. Zip Code 20715 Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ▼ No Specify: Indeptity Usual Occupation 10 NoT use retired Police Officer 18. Mother's Name 18. Mother's Name 18. Mother's Name 19. Mother or Rung Address (Street and Number or Rung Address (Street	Decity Yes or No- Decity Yes o	U.S.A. 14. Race - America Black, White, e Specify: White by the control of the c	an Indian, etc. e ustry ent Code) 14 wn, State
Physici /Medic Examin	an cal ner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ications that caused the death. Do not en the cause on each line.	2. Name and Address of Facility Role 6000 Annapolis Ros ter the mode of dying, such as cardiac ic Conchro Vac hic Canadia Vac	ad, Bowie or respiratory arrest	Maryland	Approximate Interval Between Onset and Death
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DIVISION Of VITAI RECORDS, To the Hospitel or Attending Physicien: The law requires the within 24 hours after death. To the Funestal Director: Atten this certificate has been signed completely filled in by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be	o Be Comp	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier (Check only one) 29b. Signature and title of certifier	28a. Date of Injury 28b. Time of Injury 28b. Place of Injury - At home, farm, stribuilding, etc. (Specify) 18b. Place of Injury - At home, farm, stribuilding, etc. (Specify) 18b. Place of Injury - At home, farm, stribuilding, etc. (Specify) 18b. Place of Injury - At home, farm, stribuilding, etc. (Specify) 18b. Place of Injury - At home, farm, stribuilding, etc. (Specify) 18b. Place of Injury - At home, farm, stribuilding, etc. (Specify) 18b. Place of Injury - At home, farm, stribuilding, etc. (Specify) 18b. Place of Injury - At home, farm, stribuilding, etc. (Specify) 18b. Place of Injury - At home, farm, stribuilding, etc. (Specify) 18b. Place of Injury - At home, farm, stribuilding, etc. (Specify) 18b. Place of Injury - At home, farm, stribuilding, etc. (Specify) 18b. Place of Injury - At home, farm, stribuilding, etc. (Specify) 18b. Place of Injury - At home, farm, stribuilding, etc. (Specify) 18b. Place of Injury - At home, farm, stribuilding, etc. (Specify) 18b. Place of Injury - At home, farm, stribuilding, etc. (Specify) 18b. Place of Injury - At home, farm, stribuilding, etc. (Specify) 18b. Place of Injury - At home, farm, stribuilding, etc. (Specify) 18b. Place of Injury - At home, farm, stribuilding, etc. (Specify) 18b. Place of Injury - At home, farm, stribuilding, etc. (Specify) 18b. Place of Injury - At home, farm, stribuilding, etc. (Specify) 18b. Place of Injury - At home, farm, stribuilding, etc. (Specify) 18b. Place of Injury - At home, farm, stribuilding, etc. (Specify) 18b. Place of Injury - At home, farm, stribuilding, etc. (Specify) 18b. Place of Injury - At home, farm, stribuilding, etc. (Specify) 18b. Place of Injury - At home, farm, stribuilding, etc. (Specify) 18b. Place of Injury - At home, etc. (Specify) 18b. Place of Injury - At home, etc. (Specify) 18b. Place of Injury - At home, etc. (Specify) 18b. Place of Injury - At home, etc. (Specify) 18b. Place of Injury - At home, etc. (Specify) 18b. Place of Injury - At home	nt 3 DOA Other: 4 Nursing Ho f 28c. Injury at Work? M 1 Yes 2 No reet, factory, office h occurred at the time, date and place, westigation, in my opinion, death occurred. 29c. License number	28f. Location (Stree City or Town, S and due to the caus red at the time, date	e 6 Other (Specify) out and Number or Rural state)	Route Number, ted. he cause(s)
	State jistrar	Rakesh Arora, M.D. 31. Date filed (Month, Day, Year) MAY 26 20	14300 Gallant For	x Lane, Suite 222,	Bowie, M	Maryland 20	0715

			For State Registrar	State of Ma	aryland / Dep		lealth and N	lental Hyg	iene eg. No. 2004	18443
	Physici /Medi		1. Decedent's Name (First, Middle OEN I At	o, Last) R.	WOLI	MAN		2. Date of Deat Month	Day Year	3. Time of Death
	Examir Funeral Director		4a. Facility Name (If not institution ANNE ARUNDEL ME 5. Social Security Number 220-24-8379	DICAL CENTER	e (In yrs. last birthday 74 Yrs.	Annapoli	LS If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Anne Arun Year) 9. Bin Co	
	ith the Maryland or 28a-f show	Director	10e. Street and Number	e Georges	10c. City, Town or L Mitchel	llville 10f. Zip Code	716		0g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2X No
-0036	72 hours after death with the Maryland natural', or tems 23a or 28e-f show dicul Evarinar rust be moiffied at	ed by Funeral Director	18311 Queen Ann 11. Marital Status 1 □ Never Married 2 ▼ Mar 3 □ Widowed 4 □ Divorced 15. Deceder	12. Was Decedent E Armed Forces? 1 TYPes 2 N	Ever in U.S. 13.	207 Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (Sp an, Mexican, Puerto Specify:		U.S.A. 14. Race - Ame Black, White Specify: Wh.	ite
nd 21215-0036	oe filed within 72 ial Hygiene. d other than "na	3e Completed	(Specify only higher Elementary/Secondary (0-12) 17. Father's Name (First, Middle,	College (1-4or 5	+) (Giv life. At t	e kind of work done of DO NOT use retired	during most of work 18. Mother's Name	e (First, Middle, N	Law	industry
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Baltimore,	permit. Pag Department Important: any injury once.		4 ☐ Donation 5 ☐ Other (S 21. Signature of Funger Service			2. Name and Addres	ss of Facility Rol	pert E. 1	Evans Fune: , Maryland	
8760,	rate be executed by sician and hysician and private buriar-transit the	icai Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	a consequence of):	CANC CANC CANC FAIL	PALL FR MA VRE VRE	or respiratory are	St.	Approximate Interval Between Operal and Seath Se
P.O. Box 68	ath certific thending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 1 ☐ Live birth 1 ☐ Pregnant at 1 ☐ Unknown	2 ☐ Fetal death 3i	□Ectopic pregnancy □ Other (<i>specify</i>)			23d. Date of deli Month	very Day Year
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)	To the within To the comple	Me	29b. Signature and title of certifie	luien		29c. License	3/4 2	29	d. Date signed (Manth	Day, Year)
	Sta		30. Name and address of person 31. Date filed (Month, Day, Year)	IMINS 32. Resistra	r's Signature	154 L	WELY	file!	NATOR	s, MA
10110	Registr	ar	MAY 2	5 2004	m St s	graces.				

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ORIGINAL

		i	For State Registrar	State of M	larylan	•	artment rtificate			and M		giene Reg. No. 2	004	18444
4	Physici	an	Decedent's Name (First, Middle Dorothy Rogers								2. Date of De. Month May	Day 24,	2004	3. Time of Death
	/Medio	100	4a. Facility Name (If not institution		r)		4b. City, T	own, or	Location o	of Death	riciy		unty of Death	1:35 p M
	LAGINI	ŭ.	Sunrise Assiste	ed Living					a Par			An	ne Aru	ndel
190	Funeral		5. Social Security Number 220–38–5390	6. Sex 7. A 1 ☐ M 2 🔀 F		last birthday) Yrs.	If Under 1 Months	Days Days	If Under:	Min.	8. Date of Bird (Month, Da 1-4-19	h y, Year)	Coun	
	Director		Usual Residence of Decedent		102						1-4-19	02	Mary	yland
	show	_	10a. State 10b. County MD Anne	Arundel		y, Town or Lo Verna							1	0d. Inside City Limits 1 ☐ Yes 2 🛣No
	the Ma	ecto	10e. Street and Number	Arunder		verna	10f, Zip (Code				10a Citizen	of What Cour	
	3a or	i Dir	112 Avondale Ci	ircle			,	2114	6			rog. Onizon	USA	,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show may injury or other traumatic event, the Medical Examina must be notified at an ance.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mar 3 ※ Widowed 4 □ Divorced	If Yes Give	s? ⊈ No		Was Decede		spanic Oric n, Mexican Specify:	gin? (Spe i, Puerto i	city Yes or No Rican, etc.)		Race - Americ Black, White, ecify: Wh	
21215-0036	within 72 ho ne. han "natur ne Medical i	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12)	nt's Education ist grade completed) College (1-4o	r 5+)	(Give	dent's Usual kind of work DO NOT use	k done di e retired)	urina most	t of workii	ng		of Business/Ind	dustry
land 2	ld be filed v lental Hygie ked other t ic event, th	To Be Co	8 17. Father's Name (First, Middle, William Rogen			110	incing) to				(First, Middle, Fadden			
Maryland	d 2 shou th and M 7 is mar traumat	-	19a. Informant's Name/Relations Donald Dunker/				ng Address				/ Route Number		own, State, Zip	
Baltimore,	Pages 1 an ent of Heal nt: If item 2 ry or other		20a. Method of Disposition 1	3 □Removal from Stat		Place of Dispo cometery, creat codlawr	sition (Naminatory or oth	e of her place)		28,	20c. Locati	ion · City or To	wn, State
Balti	Departm Importa any inju		21. Signature of Fundal Service			8 4	Name and arrance 95 Gov	Address O & V. R.	s of Facility Sons itchi		-			neral Home D 21146
4	Physician // Medical Examiner // Live price price // Physician and // Phys	Examiner	23a. Pagh. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	t only one cause on each	line. V C1 / Is a consequence of a cons	Monumenter of):	ia	,	g, such as			rest,		Approximate Interval Between Onset and Death
.O. Box 68760,	death certific e attending pl d for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	d	2 Feta	Ideath 3	Ectopic pre					23d.	Date of delive	ory Day Year
rds, P	.≡ v p	by	Part II. Other significant conditi	ions contributing to death	but not res	ulting in the u	nderlying ca	use give	n in Part I.			obacco use (es 2 🗀 N		ably 4 Durknown
al Records,		Completed										an 2 sy rmed? 2 No	prior to cor death?	psy findings available inpletion of cause of
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital	tiont 2	ER/Outpatier	2 DO	Othe			(Check only one 5 - Residence		Anne (Carack	Hissisted
sion of	Jing After fune	ertification: To	27. Mann f Death 1 Natural 5 Pendi 2 Accident invest	28a. Date of In ng (Month, L igation	jury	28b. Time o Injury		c. injury Work		2	28d. Describe)
Division	in the	Certific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	nined 289. Place of I	njury - At h etc. <i>(Specif</i>	ome, farm, sti (y)	reet, factory,	office		2	28f. Location (5 City or Tow		umber or Rura	l Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Diract completely filled in by	edical	29a. Certifier 1 Certifyi (Check only 2 Medical	ng Physician: To the best Examiner: On the basis and manner	of examina	owledge, deat ation and/or in	h occurred a vestigation,	it the time in my op	e, date an inion, dea	d place, a th occurre	ed at the time,	date and pla	ice, and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certific		2	ind	290,	License 50	number	25		29d. Date si	gned (Month, I	200/
			30. Name and address of person	edinger	8601	Voter	Print)	ten.	ANI	ille	rsull	o M	10 211	108
	Sta Regist		31. Date filed (Month, Day, Year	2 6 2004 32. Regi	rar's Signa	ature .	book		/			,		

DHMH/17 Rev 1/2001

ORIGINAL

				State of Maryla	nd / Dep	artmen		alth and	Mental Hy	aiene .	0 0 4	18445
	Physici /Medi Examir	cal	Decedent's Name (First, Middle, Last) Carol Ann Zeleski Ann Zeleski Facility Name (If not institution, give struster) Spa Creek Center German Spanning Comments of the	·	- C			ocation of Dea	2. Date of De Month May	Day 19 4c. Cour	Year 2004 hty of Death	3. Time of Death 8:00 PM
1/4	Funeral Director		Social Security Number 6. Sex		s. last birthday) Yrs.	-		f Under 24 Hrs Hours Min		th v Year)	9. Birthplac Country Maryla	ce (State or Foreign
	the Maryland 28a-f show	rector	10a. State 10b. County Maryland Anne Aruno 10e. Street and Number		city, Town or Lo	10f. Zip	Code			10a Citizen a	10d	1. Inside City Limits 1 Yes 2 No
	3a or	Ö	1912 Cavalier Circle	9			114		1	United		71
9036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28e-1 show or other traumatic event, the Medical Examiner must be notilised at	Completed by Funeral Director	11. Marital Status 12. 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Deced If Yes, spec		anic Origin? (S Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	- 14. R	ace - American lack, White, etc	c.
21215-0036	ithin 72 h ne. nan *natu	nplete	15. Decedent's Educal (Specify only highest grade of Elementary/Secondary (0-12)		(Give	kind of wor DO NOT us		on ing most of wo	rking	16b. Kind of	Business/Indus	stry
Maryland 21	2 should be filed within and Mental Hygiene. is marked other than sumatic event, the Mental Head.	Be	17. Father's Name (First, Middle, Last) Leo Zeleski		se	creta	11		me (First, Middle,			
2	should and Men marke	2	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailir	ng Address	!		ural Route Numbe		n. State. Zin Co	ode)
	alth a alth a 127 is		Lisa Wheeler/ daugh	ter					Rd. Har			
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra ance.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Rem 1 □ Donation 5 □ Other (Specify)	oval from State	Place of Dispo cemetery, crea akemont	osition (Nan matory or of Mem.	ne of other place) Garde	ens Ma	Date y 24, 20	20c. Location 04 Dav	i dsonvi	n, State
Balt	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Licensee	monodi		147 D	uk e o:	f Glouc	ester St	. Anna	uneral polis,	Home, Inc MD 21401
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one complicates the complex of t	cause on each line.	C(or b				c or respiratory ar	rest,	In	pproximate terval Between nset and Death
Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial transit	Physiclan/Medical Exa	in the past 12 months?	Due to (or as a conse	nancy tal death 3	Ectopic pre					ate of delivery	ıy Year
P.O.	that the dead by the detached	hysi	1 □ Yes (No 9 □ Unknown	9□ Unknown			//					
	w requires that been signed should be del	by	Part II. Other significant conditions contrib	outing to death but not re	sulting in the u	nderlying ca	ause given i	n Part I.		bacco use cor es 2□No	ntribute to the c	eause of death?
al Records,	ician: The law r certificate has be rector, page 2 sh	Completed							24a. Was autop perfor 1 \sum Yes	sy	Were autopsy prior to comple death?	findings available etion of cause of
Vital	Physician: this certificatal director, I	o Be	25. Was case referred to medical examiner? 1 Yes Wo Hos	pital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatien	it 3□ DO	Othor		th (Check only or			
	De je	ertification: T		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	-	8c. Injury at Work?		ome 5 Resid			
Division	tal or Attandir rs after death. al Director: Al ed in by the fu	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At t building, etc. <i>(Spe</i> c	nome, farm, stre	eet, factory,	, office	That -	28f. Location (S City or Tow	treet and Num n, State)	ber or Rural Ro	oute Number,
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	edical	29a. Certifier (Check only one) Certifying Physici (Check only one)	an: To the best of my kn On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred a vestigation.	at the time, in my opini	date and place on, death occu	, and due to the c rred at the time, c	ause(s) and m late and place	anner as stated and due to the	d. e cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier	CML		29c.	License nu) 03 (L-, Ms	9d. Date signe 5/2//	d (Month, Day	, Year)
			30. Name and address of person who comp	2 21031)	. Dona	Print) A	-ine	Chest	y-, Ms	2161	19	
	Sta Registr		31. Date filed (Month, Day, Near) 9, 4, 2	2004 Register's Sign	ature	Some	40					

			1 - For Amend Item 2 State Registrer			8 ¢11/040h Certificate				ene g. Ng2 () () ()	18446
	Physici		1. Decedent's Name (First, Middle, L	,				~^	ate of Death	Day Yea	3. Time of Death
	/Medic Examir		Catherine W. Zir	ive street and number)		4b. City, To	own, or Locati		109	4c. County of De	7112.75
	Funeral		5. Social Security Number 6.	Sex . Age (In yrs. last bin	thday) If Under 1			ate of Birth Month, Day,	Dar t	inthplace (State or Foreign
	Director		217-10-7555 Usual Residence of Decedent	1□M 2 X F 8	39	Yrs. Months [Days Hou	rs Min. 01	4/22/1	915 Ma	aryland
	nyland		10a. State 10b. County	1	0c. City, Town	n or Location					10d. Inside City Limits
	the Ma 28e-1 e	Funeral Director	MD Harfor	d	Havr	e de Gra			10	g. Citizen of What (1 XYes 2 □ No
	th with 23a or st be	al Dir	328 Hill Court				078			JSA	Country?
	er deal itame	uner	11. Marital Status	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 No	er in U.S.			Origin? (Specify `ican, Puerto Ricar			nerican Indian, nite, etc.
036	within 72 hours after death with the Maryland ane. than "natural", or itame 23a or 28e-f ehow na Madical Examinar must be natitied at	Ď	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 20	XNo Spec	cify:		Specify:	White
Maryland 21215-0036	n 72 ho "natur	Completed	15. Decedent's I (Specify only highest g		16a.	Decedent's Usual ((Give kind of work life. DO NOT use	Occupation done during r	nost of working	10	3b. Kind of Busines	ss/Industry
212	d withii giene. ar than	omo	Elementary/Secondary (0-12)	College (1-4or 5+)		Homemak				Home	
and	l be file htal Hy ed othe event,	Be	17. Father's Name (First, Middle, Las	()				other's Name (Firs		aiden Sumame)	
aryk	should nd Mer narke	2	Thomas Wilhelm 19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Address (S		ffie Garle mber or Rural Rou		City or Town, State,	Zip Code)
	and 2 ealth a m 27 le		Mary Teresa Hox		ter 32	8 Hill Ct	., Hay	re de G			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If Itam 27 ie marked othar than "natural", or Itame 23a or 28e-1 ehow any injury or othar treumatic event, the Madical Examiner must be natified at once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3	Removal from State	cemeter	Disposition (Name y, crematory or othe	er place)	Date		c. Location - City o	
altir	permit. P Departme Importan any injuri once.		* 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice		Holly	Hill Ceme	etery Address of Fa	105/21/04 Funeral	4 E	Saltimore,	MD
8	8989		gilaine m	J. Sm	to	123 3. 1	wasnin	gton, Ha	<u>ivre d</u>	<u>e Grace, </u>	MD 21078
	Physician /Medical		Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a.	A.	Kenal F	ailure	chroni	c)	t,	Approximate Interval Between Onset and Death
	Examiner		Sequentially list conditions.		ronic	Arterial	Insuff	iciency			
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence o pertens	•					
8760,	ate be executed whysician and the burial-transit	dlcal Exa	that initiated events resulting in death) Last	Due to (or as a co	1						
P.O. Box 6	Attanding Physician: The law requires that the death certific in death. If death. ector: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Completed by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of a 1 □ Live birth 2 □ 4 □ Pregnant at tim	Fetal death	3 ☐Ectopic pregr 5 ☐ Other (speci				23d. Date of de Month	elivery Day Year
ords, P	w requires that been signed b should be det	ted by P	Part II. Other significent conditions	contributing to death but n	ot resulting in	the underlying caus	se given in Pa	rt I. 2			to the cause of death?
Division of Vital Records,	: The law r cate has be page 2 sh	Comple							4a. Was an autopsy performe □ Yes 🍹	prior to	
Vita	ysician: The l is certificate ha director, page	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 🗆 ER/Out	patient 3□ DOA	Other I	ace of Death (Che		a F201 / /2	7.
on of	ding Phys n. After this funeral dii	lon: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye		ime of 28c.	Injury at Work?	28d. D		e 6 Other (Spe	ecity)
Divisio	Dit of	Certification:	2 Accident investigation 3 Suicide 6 Could not 4 Homicide	De Diego of laium	- At home, far Specify)	m, street, factory, of	1 ☐ Yes 2	28f. Lo	ocation (Streetity or Town, S	et and Number or R State)	tural Route Number,
	Hospitei 24 hours a Funarel l etely filled	Medical C	29a. Certifier Check only one) Certifying P	hysicien: To the best of m miner: On the basis of ex- and manner stated	amination and	death occurred at t Vor investigation, in	he time, date my opinion, d	and place, and duleath occurred at t	e to the caus he time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within 2 To tha complet	Re	29b. Signature and title of certifier	= // 0		29c. Li	icense numbe	er .	29d	Date signed (Mon	th, Day, Year)
		-	1/26	ruble M)		4	1290	00	/	5/201	104
			30. Name and address of person who	completed cause of death 3/9	(Item 23a) (T	Type, Print)	if h	106/16	1/2	1078	
1	Sta Registr	, e	31. Date filed (Month, Day, Year) JUN 1 1 2004	32. Registrar's	Signature	Spark.		1	7		

Zinn, Catherine W

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** eanix /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner DHIMO'E Bar If Under 24 Hrs. Birthplace (State or Foreign Country)
 1/1 If Under 1 Months 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Days Min. 83-20-8841 Usual Residence of Decedent 1 □ M 2 10 F Director 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Show ms 23a or 28a-f show 1 ☐ Yes 2 No Baltimore Funeral Director 10g. Citizen of What Country? 10e. Street and Number Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cultan, Mexican, Puerto Rican, etc.) 14. Race - American Indian er than "natural", or items the Modical Examiner of 11 Marital Status Black, White, etc. 1 ☐ Neyer Married 2 ☐ Married 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 þ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Unit Tech permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than any nigury or other traumatic event, II is MORE. 18. Mother's Name (First, Middle, Maiden Sumame) 17, Father's Name (First, Middle, Last) Stern 19a. Internant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru al Route Number, City or Town, State, Zip Code) Red 20c. Location - City of Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Green Mount Britimore MD Greens Funda Service 1 Burial 2 Cremation 3 □Removal from State 6-11-04 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vausino (f Funeral Service ature Randalistour MD 21133 bertullo 23a. Pain: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) as a consequence of): **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to impediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner Due to (or as a consequence of): 68760. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 menths? Month Day 5 Other (specify) P.0. detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, 4 Donknown 3 Probably 1 ☐ Yes 2 ☐ No Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? To Be Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 5 Residence 1 Tes o 28d. Describe how injury occurred in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Injury at Work? Certification: 1 Natural Injury Division 5 Pending 2 No 1 Yes investigation 2 Accident after death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determines 4 \(\text{Homicide} \) within 24 hours a To the Funerel (ertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mariner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Pay, Year) 29b. Signature and little of certifier of death (Item 32. Registrar's Signatu State

DHMH 17 Rev 1/2001

Registrar

JUN 1 4 2004

			1 = For State Registrar	State of Maryland	l / Depa		Health and	Mental Hygi	ene g. No. 2004	191.1.0
			Registrar 1. Decedent's Name (First, Middle, Last)		061	inicate or	Death	2. Date of Death		3. Time of Death
8	Physici	an	Gregory	Arsenault				June 9	Day Year	
	/Medic		4a. Facility Name (If not institution, give s			4h City Town o	or Location of Deat		4c. County of Death	6:32 A M
	Examin	er -	Laurel Regiona			Laur			Prince (
	Eupoval		5. Social Security Number 6. Sex		st birthday)	If Under 1 Year	If Under 24 Hrs			place (State or Foreign intry)
	Funeral Director		407-58-5808 ¹ ₩	M 2□F 75	Yrs.	Months Days	Hours Min.	Oct. 17	1928 Car	intry) nada
side	D		Usual Residence of Decedent							
	nylan	_	10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	e Ma	cto	Maryland Prince (George Up	per Ma	arlboro				1 ☐ Yes 2 ☐XNo
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	intry?
	ath w	-ca	16007 Marlboro Pike			207			U.S.A.	
	er de	Funeral		12. Was Decedent Ever in U.S Armed Forces?	i. 13. V	Was Decedent of the Yes, specify Cub	Hispanic Origin? (S pan, Mexican, Puer	ipecify Yes or No- to Rican, etc.)	14. Race - Amer Black, White	
36	s aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 MYYes 2 ☐ No If Yes, Give Year or Dates:	1	Yes 200 No	Specify:		SpecifyWhit	:e
Maryland 21215-0036	within 72 hours atter death with the Maryland ene. than "natural", or items 23e or 28e-f show fra Madical Exertine reast be notified at	ed t	15. Decedent's Educ		16a. Deced	ient's Usual Occur	pation		6b. Kind of Business/li	ndustry
5	in 72 n " n	Completed	(Specify only highest grade	completed)	(Give	kind of work done OO NOT use retire	during most of wo	rking	United Sta	•
212	iene r tha	Eo	Elementary/Secondary (0-12)	College (1-4or 5+) 4+	Calil	oration S	Specialis	st.	Army	
ō	Hyg othe	BeC	17. Father's Name (First, Middle, Last)					me (First, Middle, M	laiden Sumame)	
<u>a</u>	Ald be forta	ToB	Austin Arsena	ault			Winifr	ed Calhil	L1	
ar	should have	-	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailin	g Address (Street	t and Number or Ru	ural Route Number,	City or Town, State, Zi	ip Code)
Σ	alth alth 27 is		Monique Jones (Da	aughter)	16007	7 Marlbon	ro Pike,	Upper Mar	lboro, Mar	yland 20772
Baltimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐ Re	Cei	nce of Dispo	sition (Name of natory or other pla	100)	Date 2	t0c. Location - City or T	own, State
Ĕ	Page nent ent: If		`4 □ Donation 5 □ Other (Specify)	Ba1	t./Was	sh. Crema	atory 6/1	1/2004 I	Laurel, Ma	ryland
a	permit. Pages 1 and 2 should be tited within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is merked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, If a Madical Examinating the rediffied at ODEs.		21. Signature of uneral Service License	2000	22	. Name and Addre	ess of Facility F1	eck Funer	al Home, I	ne
m	88 = 8		Luphamo	MO12	50 76	601 Sandy			rel, Marv	
Ę,			23a. Part1. Enter the disease, or complication shock, or heart failure. List only on	cations that caused the deeth.	Do not ente	er the mode of dyi	ing, such as cardia	c or respiratory arre	st,	Approximate Interval Between
£.	Physician :		Immediate Cause (Final disease or condition	Respirat	ww Fe	Mura				Onset and Death
	/Medical		resulting in death)	Due to (or as a conseque		TTULE				
	Examiner		Conventially list conditions	Pneumoni	a					
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):					
	nd Irans	Examiner	that initiated events			4				
760,	te be executed ysician and te burial-transit		resulting in death) Last	Due to (or as a conseque	ence of):					
376	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	lical								
68	The law requires that the death certifical ate has been signed by the attending phrage 2 should be detached for use as the	Physician/Med	IF FEMALE:							
Box	ath ce	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetel o	death 3	Ectopic pregnanc	Э		23d. Date of deliv	very Day Year
0	e des	sici	1 Yes 2 No	4☐ Pregnant at time of dea 9☐ Unknown	ath 5	Other (specify) _				54,
<u>Ф</u>	d by letach	Phy	Part II. Other significant conditions con	tributing to death but not recul	ting in the u	ndorheina aguso au	von in Bod I	23e Did tob	acco use contribute to	the cause of death?
	w requires that been signed be should be det	b	Coronary Artery I	_	ung in the di	raditying dause gr	VOITHIT AILT.		s 2 No 3 Pro	
orc	neen :	eted							LUACO C	
ec	e law has b je 2 sl	Completed by	Abdominal Wound D	ehisence				24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
Vital Records,		S	Pancreatitis					perform 1 Yes 2	ed? death? ✓ No 1 ☐ Yes	2 🗆 No
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:	/	0#	han	ath (Check only one		
of	S S	2	1 Tes 219 No	1 Inpatient 2 VE	R/Outpatien	1 3FI DOV			nce 6 Other (Speci	ify)
no O	ing F After uner	lon	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	Wo	ork?	28d. Describe how	w injury occurred	
Division	Attending r death. sctor: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hon	no form at]Yes 2 □No	29f Location (Str	eet and Number or Rur	m I Pouto Number
\leq	or Al	ırtif	4 Homicide determined	building, etc. (Specify)	ne, raim, sm	eet, factory, office		City or Town,	State)	ar noble reamber,
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ŭ	29a. Certifier 1 ▼ Certifying Phys	sician: To the best of my know	ledge dest	a occurred at the t	ime date and place	and due to the an	lieg(e) and manner co	stated
	24 hi Fun stely	edical	(Check only 2 Medical Examinations)	ner: On the basis of examination and manner stated.	on and/or in	vestigation, in my	opinion, death occi	urred at the time, da	te and place, and due	to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and tille of certifier	0	1	29c. Licen:	se number	29	d. Date signed (Month,	, Day, Year)
	- 5 - 0		> (V)	Laval	1	D52	2261		June 9, 200	04
	17X		30. Name and address of person who co	mpleted cause of dath (Item	23a) (Type	(rint)				
	12		Dr. Alan R. Segal	1-1			00 Fores	t Glen Ro	ad, Silver	Spring MD
<u> </u>	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure		JU TULES	C OTCH RU	DITYEL	phing in
	Regist		JUN 1 4 2004	Bona . K	Boock	2				

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 _ State	ate of Maryland				lental Hy		1 10150
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of	Death	2. Date of De	Reg. No. 2 U U	3. Time of Death
	Physici		CHRISTINA	M. A	117	ALONE	_	Month	-	ear /
	/Medid Examir		4a. Facility Name (If not institution, give stree		10 2		r Location of Death	1014 1	4c. County of [Death
			GILICHTEST HOS	spice		Tou	uson		BAL	Timore
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	* .	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h v. Year) 9.	Birthplace (State or Foreign
	Director		2/7 - /6 - 0 22 7 1 M. Usual Residence of Decedent	94	Yrs.			JULY 2	9,1909	CONN
	land ow		10a. State 10b. County	. 10c. City,	Town or Loc					10d. Inside City Limits
	Mary -1 sh	ģ	MD BALTI	More		PARKUL	lle			1 Tes 2 No
	ith the Marylar or 28e-f show	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	it Country?
	23a c	aiD	7923 HiGhPoint	RS		2	234		0.3	5.A.
	be filed within 72 hours after death with fhe Maryland be filed within 72 hours after death with fhe Maryland of other then "neturel" or tems 23a or 28e-f show event, the Medical Exam not must be invitibled at	Funeral Director	A	as Decedent Ever in U.S. med Forces?	13. V	Vas Decedent of H Yes, specify Cub	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, V	American Indian, White, etc.
36	rs afte	by F	1 Never Married 2 Married 1 3 Widowed 4 Divorced	☐Yes 2☐No Yes, Give ear or Dates:	1	□Yes 2☑No	Specify:		Specify:	white
21215-0036	2 hou	ted	15. Decedent's Education	1	16a. Deced	ent's Usual Occup	ation		16b. Kind of Busin	
7.	hin 7: 9. 9n 'n	Completed	(Specify only highest grade con Elementary/Secondary (0-12)	ollege (1-4or 5+)	(Give I life. D	kind of work done O NOT use retired	during most of work d)	ing		,
	ed within ygjene. er then t, the M	Con	7th	NA		Homen			Hom	2
<u> </u>	tal Hydral Hydral of hoth	Be	17 Fether's Name (First, Middle, Last)	-					Maiden Surname)	
Marviand	2 should be filed von and Mental Hygie is marked other treumetic event, the	2	1 thill GenT 19a. Informant's Name/Relationship (Type, F		40E M-10-	- Add (Ct		nces	Perre	
<u></u>	ogs 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Martel Hygienshall in the Maryla filems 21 is marked other then "neturel", or flems 23a or 28e-1 should filem 27 is marked other then "neturel", or flems 23a or 28e-1 should on other treumetic event, the Medical Example of mast the modified at		Dolores AMIC	rint)	790. Mailin	4.		^	or, City or Town, Sta 1 1 to My	
و	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre		20a. Method of Disposition		ce of Dispos	ition (Name of	1 [Date	20c. Location - City	
Baltimore	Pages nent of t		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removed 4 ☐ Donation 5 ☐ Other (Specify)	al from State	RDENS	of Fa.	. 1 1. 1	104	Rolls N	IN.
<u>=</u>	permit. Departm Importe any inju		21. Sr nature of Funeral Service Licensee	O TO			- 1		mo 212	3 4
ď	permi Depar Impor any ir		faul M.	stells.	H	9RTICY N	tiller -5.	tella t	uneanl 1-	3 Y tome CHTD.
			23a. Part . Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused the death. use on each line.						Approximate Interval Between
	Priysician	1	Immediate Cause (Final disea e or condition	Lun	9	Cance	R			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque	no-/of):					
8		P	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	nce of):					
00	ute d	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.		,					
. \ 6	exect an and rial-tra	Exa	resulting in death) Last	Due to (or as a conseque	nce of):					
→O.	The law requires that the death certificate be executed attended to the attending physician and page 2 should be detached for use as the burial-transit	edicai	d							
	artifica ing pt	Med	IF FEMALE:							
(O)	eath certific attending p	Physician/M	23b. Was decedent pregnant	yes, outcome of pregnanc □Live birth 2 □ Fetal de	eath 3 🗌	Ectopic pregnancy	,		23d. Date of Month	delivery Day Year
9	at the de by the a tached t	ysic		□Pregnant at time of dea □Unknown	th 5∐	Other (specify)				- ay
ہے ہے	that the do	/ Ph	Part II. Other significant conditions contribu	ting to death but not resulti	ng in the un	derlying cause giv	en in Part I.	23e. Did to	bacco use contribut	te to the cause of death?
Stuna ecords.	w requires that been signed to should be det	ed by						1 🗆 Y	es 2□No 3□	Probably 4 Unknown
40	s bee	ojete						24a. Wasa	an 24b. Were	a autopsy findings available
	The law	Completed						autop perfor 1 Yes	med? deatl	to completion of cause of h? Yes 2 No
		Bec	25. Was case referred to medical examiner?				26. Place of Death			
びる	Physicien: this certific	은	1 ☐ Yes 2 No Hospii	I _ Inpatient 2 _ EF			4 Nursing Hol	me 5 🗆 Resid	ence 6 Other (S	Specify) Hospice
9) =		ion:		a. Date of Injury (Month, Day Year)	Bb. Time of Injury	28c. Injur Wor		28d. Describe h	ow injury occurred	. /
	or Attendiater death. Director: A	icat	2 Accident investigation 3 Suicide 6 Could not be	e. Place of Injury - At hom-	e farm etra		Yes 2 □No	28f Location /S	treat and Number of	r Rural Route Number,
	l or Attendation after death Director:	Certification:	4 Homicide determined	building, etc. (Specify)	e, iaiii, sile	et, ractory, office	ľ	City or Tow	n, State)	Hurai Houte Number,
2	spite nours nerel		29a. Certifier 1X Certifying Physicien	n: To the best of my knowle	edge, death	occurred at the tin	ne, date and place, a	and due to the c	ause(s) and manne	r as stated.
Anzala	To the Hospitel or Attending within 24 hours after death of the Funerel Director: After completely filled in by the fune	Medicai	(Check only 2 Medical Examinar: (On the basis of examination and manner stated.	n and/or inv	estigation, in my o	pinion, death occurre	ed at the time, o	late and place, and	due to the cause(s)
T	To t To tl	Σ	29b. Signature and title of certifier	10	, -	29c. Licens	e number	2	29d. Date signed (M	onth, Day, Year)
			1 / Hoth	7/my	, un	1 12	7 202		JUNE /	m 2, 200 4
	5		30. Name and address of person who comple	ted cause of death (Item 2	3a) (Type, F	rint)	r. 1. 0.	Ct	Balta	md 2,226
	Sta	to	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	e A M	2	- conce		,	
0	Registr		31. Date filed (Month, Day, Year) JUN 1 4 2004	week and of	CALLACT	Sept.				

			For	State	of Maryla		artment of F		nd Mental		2001	101 - 1
			Registrar 1. Decedent's Name (First, Midd	le (ast)		061	tineate or	Deatir	2. Date of	Reg. No.	2004	3. Time of Death
	Physici	an	DIANE M. BOA						Month	Day	Year 2604	Α
3	/Medic Examin		4a. Facility Name (If not institution		ımber)		4b. City, Town, o	r Location of			County of Death	
	LXdiffit		UNIVERSITY OF ,	MARYLAND	MEDICA	AL CENTER	BA	+LTIME	OKE		NIF	+
	Funeral		5. Social Security Number	6. Sex		rs. last birthday)	If Under 1 Year Months Days		4 Hrs. 8. Date of	of Birth	9. Birth	place (State or Foreign intry)
	Director		213-88-8688	1 □ M 2 💢 F		41 Yrs.	Michiel Gayo		AUG.			yland
	and *		Usual Residence of Decedent 10a. State 10b. Count	,	10c.	City, Town or Lo	ocation					10d. Inside City Limits
	Maryl faho	ō	MD		Bal	ltimore						1 ☐ Yes 2 ☐ No
	the 128a	Director	10e. Street and Number				10f. Zip Code			10g. Citi	izen of What Cou	intry?
	3a ou		1163 Nanticok	e Street			21230	0		USA		
	death	Funeral	11. Marital Status		cedent Ever in	1 U.S. 13.	Was Decedent of H	lispanic Orig	pin? (Specify Yes of	r No-	14. Race - Amer Black, White	
9	or Its	F	1 ☐ Never Married 2X Ma	rned 1 ☐ Yes If Yes, G	2 X No		1 ☐ Yes 2 💢 No	Specify:	, r dono rnodn, oto	.,		nite
21215-0036	72 hours after death with the Maryland natural; or Itams 23a or 28a-f ahow ilral Examinar must be notified at	d by	3 Widowed 4 Divorce	Year or l	Dates:					1	***************************************	
- 2	72 In a	Completed		nt's Education est grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	durina most	of working	16b. Ki	ind of Business/Ir	ndustry
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	be filed Ital Hygid of other event,	Be C	17. Father's Name (First, Middle				Jack Control of the		's Name (First, Mi			city beneets
lan		O B	Charles Willi	ams Simms	, Jr.			Tere	sa Heila	nd		
Maryland	12 should h and Mer 7 is marks traumatic	_	19a. Informant's Name/Relation	ship (Type, Print)		19b. Maili	ng Address (Street				r Town, State, Zi	p Code)
			Christopher Bo	ardman - 1			Nanticoke	e St.,	Baltimo	re, MD	21230	
ore	100		20a. Method of Disposition 1 ☐ Burial 2 M Cremation	3 □Removal from	Clata		natory or other place		Date	20c. Lo	ocation - City or T	own, State
Ĕ	Pages ment of ant: If it ury or o		`4 □Donation 5 □ Other (Ba	altimore	Wash. C	rem. 6	/12/04	La	urel, MI)
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service	Licensee Factor a	~	Ga	2 Name and Addre 1ry L. Kau 250 Washir	ufman '	Funeral :	Home@1	Meadowri	dge MP, Inc.
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that t only one cause on	caused the de							Approximate Interval Between
4	Priysician		Immediate Cause (Final disease or condition	. 1	SCHEMI	c cAi	RDIOMYON	PHTAS			J	Onset and Death
	/Medical		resulting in death)	Due to	(or as a cons			,				
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_	and and Il-tran	Examine	that initiated events resulting in death) Last	c	o (or as a cons	sequence of):						
8760	ate be executed thysician and the burial-transit				·							
687	ficate physics the	edical		0.								
Вох	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pre		75				23d. Date of deliv	very
	deatle atte	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2 ☐ Fo gnant at time o		Ectopic pregnancy Other (specify)	<u> </u>		_	Month	Day Year
P.0	at the de by the	hys	9 🗆 Unknown	9 Onk	nown							
Ś	es that igned to be deta	by F	Part II. Other significant condit	ions contributing to	death but not i	resulting in the u	nderlying cause giv	en in Part I.				the cause of death?
Record	w requir been si should	ompleted								1 ☐ Yes 2 [□No 3□Pro	bably 4 2 Onknown
Ö	e law n	ble								Was an autopsy		opsy findings available ompletion of cause of
H		Con							1 🗆 Y	performed? es 2 No	death? 1 ☐ Yes	2□ No
Vital	ician: Th certificate ector, pag	Be	25. Was case referred to medic examiner?	Hoonitali			Oth	OF.	of Death (Check o			
of	Phys this al dii	2	1 Yes 2 No 27. Manner of Death	28a. Date		28b. Time o		4 1901	rsing Home 5	Residence (fy)
n		tlon	1. Natural 5 ☐ Pend		nth, Day Year) Injury	Wor	k? Yes 2∐N		noe now injur	y occurred	
Division	if or Attandi after death. Diractor: A d in by the fu	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Plac	e of Injury - A	t home, farm, str	reet, factory, office		28f. Locati	on (Street an	d Number or Rur	al Route Number,
Ö	after after Dirac	Certification:	4 Homicide	buik	ding, etc. (Spe	ecify)			City o	r Town, State)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attention to the fune completely filled in by the fune	Medical C		ing Physician: To the								
	o tha ithin (o tha omple	Mec	29b. Signature and title of certif		or stated.		29c. Licens	e number		29d. Dat	e signed (Month,	Day, Year)
	r s r ō		Alux 11	who MD			A04176	11201	14549	_	SUNE 10	2004
	h		30. Name and address of perso	n who completed cau	use of death (i	item 23a) (Type,		7 2) [11171		10,	2004
			AHMET KILL	C	225	GREEN	E ST.		BALTIM	ORE,	40 2	1201
	* Sta		31. Date filed (Month, Day, Yea		Registrar's Sig		1 .					
c.	Regist	rar	JUN 1 4 2	UU4 24	wa	D,	sporks					

		riease i		it in Black in				_	Die.
		For	State of Ma	aryland / Dep			lental Hy	- A - A	0.01
		1 - State Registrar		Ce	rtificate of	Death		Reg. No.	104 18452
Physic	ian	Decedent's Name (First, Middle, Last)					2. Date of De. Month	ath Day	3. Time of Death
/Medi			urgin				Juse		04 x 5071M
Exami	ner	4a. Facility Name (If not institution, give	1 . 1	1.		or Location of Death		4c. County	
		Jorth Arunde 5. Social Security Number 6. Sec			(Jejes)	If Under 24 Hrs.	D D-44 Di-	ANN-	
Funeral Director			M 2□F	e (In yrs. last birthday) 68 Yrs.	Months Days		B. Date of Bird (Month, Da	y, Year)	Birthplace (State or Foreign Country)
		Usual Residence of Decedent		00			Oct. 0:	2 1935	LA
nylan how	1.	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
the Marylan 728a-f show	cto	Maryland Anne Ar	undel		Gle	n_Burnie			1 ☐ Yes 2 ☑ No
€ o €	Olre	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country?
of f	Funeral Director	1122 Leonard Driv				21060			USA
If and a second	une		12. Was Decedent I Armed Forces?	Ever in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	- 14. Race Blace	e - American Indian, k, White, etc.
36 136 urs aft		1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:	40	1 ☐ Yes 2 🗓 No	Specify:		Specify	· White
5-0036 72 hours at matural; or alteral Evaluation	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Bu	usiness/Industry
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d 212 d 212 filed with Hygiene. whar ther	Son	12			Computer	Science		Federa	1 Government
be filed that Hyging of other event, I	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			θ)
Maryland d 2 should be fill th and Mental H T is marked oth	2	Floyd Burg				Viola		lland	
re, Maryla s 1 and 2 should Health and Mer Item 27 is marke		19a. Informant's Name/Relationship (Ty)				and Number or Rura			
5 ± W F		Bernadette B. Bur 20a. Method of Disposition	gin (spo	OUSE) 112 20b. Place of Dispo		d Drive. (City or Town, State
V 0 0 0 = 5		1 X Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Meadowri	matory or other pla		04		e, Maryland
		21. Signature of Funerat Service Licens			2. Name and Addre		-		
Balti Barrit. Departi Importa eny inje	ļ	12.	the de				otalling	Js Funer	al Home, P.A.
11.00		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused	the death. Do not en	ter the mode of dyir	ntain Roac ng. such as cardiac c	r respiratory an	rest,	Approximate
Physician		Immediate Cause (Final disease or condition	2) S (S					Interval Between Onset and Death
/Medical		resulting in death)				1 0	1		
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760, te be execut ysician and	calE		Rher	4	Lung	Dicence			
17 2 5 0			l						
Box 68 eath certifica attending phy for use as th	/W	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of					23d Date	e of delivery
Batte for for	by Physiclan/Medl	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth : 4 ☐ Pregnant at t	_]Ectopic pregnancy] Other <i>(specify)</i> _	/		Mon	•
P.O. that the detached detached	hys	9 🗆 Unknown	9□ Unknown						
Division of Vital Records, P.O. I or Attending Physician: The law requires that the dafter death. Director: Atter this certificate has been signed by the lin by the funeral director, page 2 should be detached.	by P	Part II. Dther significant conditions con	tributing to death bu	it not resulting in the u	nderlying cause giv	ren in Part I.	23e. Did to	bacco use contri	bute to the cause of death?
cords, wrequires been sign should be	ted						1 🗆 Y	es 2□No	3 ☐ Probably 4 ☐ Unknown
ecc law r	Completed						24a. Was a	24b. W	ere autopsy findings available rior to completion of cause of
The The page	Con						perfor 1 ☐ Yes	med de	eath? □ Yes 2 No
f Vital Rec nysician: The lav is certificate has director, page 2	Be	25. Was case referred to medical examiner?	-/			26. Place of Death	(Check only or	ne)	
Of Physical direction	5	1 Yes 2 No	ospital:			4 Inursing Hon			
On ding h.	tlon	1 ≤Natural 5 ☐ Pending	2Ba. Date of Injury (Month, Day	y 28b. Time of (Yeer) Injury	Wor	yat k? Yes 2 □ No	Bd. Describe h	ow injury occurre	ed
Attended death ctor:	flca	3 Suicide 6 Could not be	2Be. Place of Iniu	ry - At home, farm, str			98f Location (S	treet and Numbe	r or Rural Route Number,
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ospita hours mara y fille		29a. Certifier 1 Certifying Phys	ician: To the best o	f my knowledge, death	h occurred at the tin	ne, date and place, a	and due to the c	ause(s) and man	ner as stated.
Division of To the Hospital or Attending Ph within 24 hours after death. To tha Funaral Diractor: After th	edical	(Check only 2 Medical Examin	and manner stat	examination and/or in-	vestigation, in my o	pinion, death occurre	d at the time, d	ate and place, a	nd due to the cause(s)
To I To I	Σ	29b. Signature and title of certifier	10.0	Ter 171	29c. Licens	e number	2	9d. Date signed	(Month, Dey, Year)
		- Xerric.	MAN	- VY 11.1			1	June 1	1, 2004
$\overline{\Omega}$		30. Name and address of person who co	mpleted cause of de	eath (Item 23a) (Type,	Print) WOA	al Dun:	Cle.	Burne	MD. 7:0/-1
Sta	to	31. Date filed (Month, Day, Year)	32. Registra	- 1	, , , , ,		1	- 6 6 6	13 61001
Regist		JUN 1 4 2004	Brate .	H Knows	20				

WILLIAM BAKER unpend item#23a,27,28a-f,HR ME,0832,6/17/0/eg
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-03652 arend iten#11,12,15 State of Maryland / Department of Health and Mental Hygiene

1- State
Registrar RKD Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** WILLIAM 31, MAY 2004 /Medical 2:48P 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 3164 RAVENWOOD AVE 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 M 2 ☐ F Months 216-50-3121 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic svent, the Medical Exacutational Le rivillied at Balt more 1 Yes 2 □ No Directo MARYLand 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō SA Items 23a 3164 Wood Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after a and Mental Hygiene. Is marked other than "neturel", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BLack 3 D Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BORSL meats 11th acking CRI 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Baker tairmean Willie 6. 19a. Informant's Name/Relationship (Type, Print) Rother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 Is n eny injury or other traum BAKER 4609 fanacea WALLace 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ■Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) Parkivood Cometery 04 21. Signature of Funeral Sprince Live 22. Name and Address of 4.11KRD BROAKINAY Balto. 639 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause the particle and the complete complete the complete complete complete the complete com Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit certificate be executed attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2 No 1 Yes 2 □ No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 X Yes 2 □ No 4 ☐ Nursing Home 5 ☐ Residence 6X Other (SpecifySCENE this 28a. Date of Injury /Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Natural 5 Pending 4/29/04 3:00 pM 24 hours after death. Prunerel Director: A 1 Yes 2 No 2X Accident investigation subject fell off porch filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide other residence 3164 Raverwood ave., Baltimore, MD 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 0 O.C.M.E. JUNE 1,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUBIO, MO ANA 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 1 4 2004 DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 05 A M Month **Physician** BROWN 2004 06 1 8 /Medical ar If Under 24 Hrs. B. Date of Birth (Month, Day, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Battimore 7. Age (In yrs. last birthday) (State or Foreign **Funeral** Months Days 1 □ M 2 1 7 F Yrs. Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar mast be notified at 1 Yes 2 No Directo NH 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 14. Race -11. Marital Status American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No SIACK 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ntary/Secondary (0-12) College (1-4or 5+) lerica 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) To Be and Mental Williams 19b. Mailing A. dress (Street and Number or R. ral Route Number, City or Town, State, Zip Code) f Health item 27 i other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☑ Cremation 3 □Removal from State * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Greene Funeral Stres 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NTRA CEPEBRAL HEMORFHAGE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ✔️DUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 Yes 2 No 2 No 1 ☐ Yes rs after deam. ral Director: After this certum... Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 28c. Injury at Work? Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending 1 Tyes 2 No 2 Accident investigetion

6 Could not be determined 3 🔲 Suicide 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CEASIN

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

JUN 1 4 2004

32. Registrar's Signature

filled in t 24 hours a

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			Pleas 1_ For State		Print in Black II Maryland / Dep	artment of H	lealth and M		•	. 191.55
			Registrar 1. Decedent's Name (First, Middle,	(act)	Ce	ertificate of I	Death		Reg. No. C U U	* 10400
	Physici /Medi		Adele M. Bau	ernfiend				2. Date of De Month June 7	, 2004 Yea	9:06 P M
	Examir	ner	4a. Fecility Name (If not institution, g		ber)		Location of Death		4c. County of De	
-	Funeral		Charlestown Car 5. Social Security Number 6		. Age (In yrs. last birthda)	Catons\ () If Under 1 Year	/111E	8. Date of Birt	Baltim	
	Director		213-10-6635 Usual Residence of Decedent	1□M 2ÅF	B7 Yrs.	Months Days	Hours Min.	(Month, Da		irthplace (State or Foreigr Country) Maryland
	d within 72 hours after death with the Maryland jiene. r then "netural", or Items 23a or 28a-f show the Madical Exarther must be notified at	_	10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	8a-f 1	Director	MD Baltim	ore	Catons	ville				1 ☐ Yes 2 ☑ No
	with th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What (
	eath 1	Funerai	719 Maiden Choic			21 228	in- ania Orinina (S-			States
10	fter d	Fun	1 ☐ Never Married 2 ☐ Married	Armed Ford	eș?	. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	Bican, etc.)	Black, Wh	nerican Indian, nite, etc.
936	urs a	þ	3√ Widowed 4 □ Divorced	If Yes, Give Year or Dat		1 ☐ Yes 2 X No	Specify:		Specify:	White
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2	within ene. then "	npie	Elementary/Secondary (0-12)	College (1-	4or 5+) life.	DO NOT use retired)	iiig		
2	ifiled w Hygier other ti		12 17. Father's Name (First, Middle, La	ctl	<u> </u>	omemaker	10.14-15-1-1-1		Own Hor	ne
Maryland 21215-0036	ed at b	Be c	Casper Meuse				18. Mother's Name		Wilhelm	
Z	S D E E	ဥ	19a. Informant's Name/Relationship		19b. Mai	ling Address (Street a			r, City or Town, State,	Zin Code)
	1 and 2 : Health ar em 27 is ther trau		Mr. William Hilg	artner/fr	riend 119	64 Park He	eights Ave	e. Owing	gs Mills, [MD 21117
J.	es 1 a of Hea fitem r othe		20a. Method of Disposition		20b. Place of Disp	osition (Name of amatory or other place	۵) ا	Date	20c. Location - City of	r Town, State
Ē			1 ☐ Burial 2 🂢 Cremation 3 1 ☐ Donation 5 ☐ Other (Special Control of Cont		tate	Service Co	· .	3/2004	Towson, M	MD.
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Furteral Service of	erre.	1	22. Name and Addres	Rut		on Funeral aryland 212	Home, Inc.
	30.7	V	23a. Part1. Enjer the disease, or co shock, or heart failure. List on	mplications that car	used the death. Do not en	nter the mode of dying	g, such as cardiac o	or respiratory ari	est,	Approximate Interval Between
22.	Physician		Immediate Cause (Final disease or condition		Reptired	Abdomin	W Aur	49		Onset and Death
78	/Medical Examiner		resulting in death)	Due to (o	r as a consequence of):					4
À	- Administra	_	Sequentially list conditions,	b. Constitution						
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99	tificat ig phy as thi	ledi		- 0.						
P.O. Box	res that the death certificate signed by the attending phys be detached for use as the	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birt	nt at time of death 5	□Ectopic pregnancy □ Other <i>(specify)</i>			23d. Date of de Month	elivery Day Year
	Attending Physician: The law requires that the rideath. rideath. ector: After this certificate has been signed by the theretal director, page 2 should be detached by the funeral director, page 2 should be detached.	by Pi	Part II. Other significant conditions	contributing to dea	th but not resulting in the	ınderlying cause give	n in Part I.	23e. Did to	bacco use contribute t	to the cause of death?
Vital Records,	w require been sig should b							1 🗆 Y	es 2□No 3□P	robably 4 Unknown
900	aw re	Completed						24a. Was a		utopsy findings available
m	Physician: The law r this certificate has ral director, page 2 (E O						autops perform	ned? death?	completion of cause of s 2 2 No
ita	ortifica ctor.	Be	25. Was case referred to medical examiner?				26. Place of Death			, 20110
	Physic this or al dire	2	1 Yes No	Hospital: 1 ☐ Inp	patient 2 ER/Outpatie	nt 3 DOA Othe	r: 🔉 Nursing Hon	ne 5 🗌 Reside	ence 6 Other (Spe	ecity)
n c	ding P. h. After (on:	27. Manner of Death 1∞ Natural 5 ☐ Pending		Injury 28b. Time of Injury	Work		28d. Describe ho	ow injury occurred	
Sic	tend death tor: /	icat	2 ☐ Accident investigate 3 ☐ Suicide 6 ☐ Could not	he -			es 2 □No			
Division of	- 0 -	Certification:	4 ☐ Homicide determine	286. Place of	f Injury - At home, farm, st _I , etc. <i>(Specify)</i>	reet, factory, office	2	28f. Location (St City or Town	reet and Number or R n, State)	ural Route Number,
	To the Hospital of within 24 hours aft To the Funeral Discompletely filled in		29a, Certifier 10 Certifying F	hvsician: To the b	est of my knowledge, deal	h occurred at the time	e date and place a	and due to the or	auco(s) and manner a	a state of
	e Ho 124 h e Fui letely	Medicai	(Check only 2 Medical Extended)	aminer: On the bas and manne	is of examination and/or in	vestigation, in my opi	inion, death occurre	ed at the time, d	ate and place, and du	to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed (Moni	th, Day, Year)
	./)	/ , v	-17	1)	イトヤイト		J-ne 8 2	2004
	5		30 Name and address of person who		of death (Item 23a) (Type,		ane C	at-nsv:1	le Ma	gler.
	Sta		31. Date filed (Month, Day, Year)	32. Reg	jistrar's Signature	1				
	Registr		11114 4 4 2001		4	Land,			-	
DH	VIH 17 Rev 1/20	001	JUN 1 4 2004		All A	wars				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For Stete Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year MARIE Τ. BAUTZ 10:45 A.™ JUNE 2004 8. 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death HOSPICE OF BALTIMORE GILCHRIST CEN. TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 02-24-1907 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 1 □ M XX F 218-50-6159 97 MARYLAND Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 💢 💢 o BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? BOULEVARD 8800 WALTHER 21234 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes X X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: ¥ ₩ Widowed 4 □ Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SAINT JOSEPH HOSPITAL HOSPITAL VOLUNTEER YEARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **HENRY** F. MEYER GERTRUDE CORMACK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBORAH B THOMPSON (DAUGHTER) 313 S.OCEAN TRACE ROAD,ST.AUGUSTINE,FLORIDA,32080 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 06-11-2004 TOWSON, MD., 21204 MOUNT MARIE CH.CEM. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD R. D. Ruth RUCK TOWSON FUNERAL HOME, INC. TOWSON.MD.21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final distaL right Femur week disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

Physician /Medical Examiner

Department of Health a Important: If item 27 Is any injury or other tra

Physician

/Medical

Examiner

Funeral

Director

iral, or items 23a or 28a-f show Examble must be notified at

Baltimore, Maryland 21215-0036

d 2 should be filed within 7: h and Mental Hygiene. 7 Is marked other than "n:

Director

Funeral

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Box 68760

P.O.

Vital

of

Division Hospital or Attending

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within 2.

Physician/Medical Ş Completed Be Certification:

IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. winny

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4☐Pregnant at time of death

3 Ectopic pregna 5 Other (specify) 23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

autopsy performed? 2 🗆 No 1 Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 Yes

Dav

Year

1¥Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 Homicide

(Check only one)

29a. Certifier

Medical

5 Pending investigation 6 Could not be determined

sepsi S

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) may 28,2004 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home

28b. Time of 6:20 AM

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Tes 2 No

28d. Describe how injury occurred Tell while preparing Breakfast

Location (Street and Number or Rural Route Number, City or Town, State) 8800 WALTHER BLUS, ApT 1620 PAVENILLE 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

25. Was case referred to medical

Brothen

29c. License number 25205

St. Balgo Md 2120>

29d. Date signed (Month, Day, Year) MAY 8, 200x

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles W. A. Riley 6701 GBMC

31. Date filed (Month, Day, Year) JUN 1 4 2004

32. Registrar's Signature

Registrar

			1 - For State of Maryland / Department of Certificate of Registrar			ene2004	18457
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici		John Swindells Bidwell		June 11	Day Year	9:22 P M
	/Medic Examin			n, or Location of Death	Dune 11	4c. County of Dee	7.66
	CAGIIII		12261 Roundwood Road #1515 Lui	therville		Baltin	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye	ear If Under 24 Hrs.	8. Date of Birth		hplace (State or Foreign
	Director		042-16-9418 11XM 2 F 83 Yrs. Months Da	,	Aug. 18.	1920 Cor	nnecticut
	p .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				
	anyla shov	_					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	he M	ectc	Maryland Baltimore Lutherville		1		
	with a or 3	급			10	g. Citizen of What Co	
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Plygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Ammed Forces? If Yes, specify C If Yes, Give 1942-1946 12. Was Decedent Ever in U.S. If Yes, specify C If Yes, Sinve 1942-1946	of Hispanic Origin? (Spi Cuban, Mexican, Puerto No <i>Specify:</i>	Rican, etc.)	Black, Whit	
Õ	2 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Oc		1	6b. Kind of Business	
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7	Agien Per th	5	4 Manager			Department	Store
2	be file	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name	First, Middle, M.	aiden Sumame)	
Sa	should Ind Men	၉	Robert Samuel Bidwell	Susa		indells	
a	2 she and is m		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Str.				
~	and lealth m 27 her t		Elizabeth Bidwell Wife 12261 Roundy				e, Maryland
5	ges 1 of H if ite		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State	place)	Date 2	0c. Location - City or	Town, State
Ë	. Pag tment tant: jury		`4 □ Ponation 5 □ Other (Specify) Hilltop Service (-2004	Towson	Maryland
Baltimore,	permit. Depart Import any inj		21. Signature of Funeral Service Liounday 22. Name and Ad 1050 York	Ruc	k Towson Towson,	Funeral H Maryland	lome, Inc. 21204
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of a shock, or heart failure. List only one cause on each line.	1	W 4		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) a. It has 105 cleratic and 10 pue to (or as a consequence of):	vascular	Disease	2	15 years
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		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
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0	e exe ian ar ıriai-t		resulting in death) Last Due to (or as a consequence of):				
8760,	cate be executed obysician and the burial-transit	dical	d				
9		Med	IF FEMALE:			'	
Вох	eath certific attending p	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregna			23d. Date of deli	very Day Year
ö	the a	yslc	1 □ Yes 2 □ No 4 □ Pregnant at time of death 5 □ Other (specify, 9 □ Unknown)			Day Tou.
۵.	es that the de igned by the be detached	F.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	oiven in Part I	23e Did toba	cco use contribute to	the cause of death?
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as					2 No 3 Pr	1/
ိပ္ခ	e law r has be je 2 sh	Completed			24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
<u>~</u>	The page	S			performe 1 ☐ Yes 2)	ed? death? QNo 1 ☐ Yes	a∕Q No
/ita	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	26. Place of Death			-
=	Physic this c	ို	Tampanoni Zalenosipanoni Sabox	Other: 4 Nursing Hor	me 5 Residen	ce 6 □Other (Spec	city)
Ē	ing P	ë.	1 Matural 5 Pending (Month, Day Year) Injury V	Nork?	28d. Describe how	injury occurred	
sio	tendi leath tor: A	cati	a Could not be	☐Yes 2☐No			
Ξ	or At	Certification;	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	pital ours a erai I		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the	[4]			
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate hi completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the 2 Medical Examiner: On the basis of examination and/or investigation, in m and manner stated.	y opinion, death occurre	and due to the cau ed at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	Veith To t	Σ		ense number	290	d. Date signed (Month	, Day, Year)
			Institute MU Deputy DIS	8667	1.	une 12 2	2604
1	2+1			uthorville	, ,		
10				-uthorville	Marylan	'9 SIBA	3
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature		,		
	negistr	aı	JUN 1 4 2004 Bereio & South	•			

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	ate of Maryland		artment of Hertificate of L			giene leg. No. 2 (004	181.50
	Physic /Medi		Decedent's Name (First, Middle, Last) Minnie			Barbei	c	2. Date of Dea Month June	th Day	Year 2004	3. Time of Death 7:55p. M
100	Examir		4a. Facility Name (If not institution, give stree Blue Point Nursin			4b. City, Town, or Baltimon	Location of Death	June	4c. County		7.330.
i c	Funeral Director		5. Social Security Number 6. Sex 1 M	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 04 05	Year)	9. Birthpla County	ace (State or Foreign
	show	or	Usual Residence of Decedent 10a. State 10b. County		Town or Lo					10	d. Inside City Limits 1 Yes 2 No
	r 28a-f	Director	MD NA 10e. Street and Number	Ball	timor	10f. Zip Code		1	0g. Citizen of V	What Counti	
	23a c	rai D	5130 Pembridge Av	'e		213	215		U.S	. A .	
336	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Estroller Frust Re Indiffed at	by Funeral	1 ☐ Never Married 2 ☐ Married 1	/as Decedent Ever in U.S med Forces? ☐ Yes XXNo Yes, Give ear or Dates:		Was Decedent of His f Yes, specify Cuban 1 ☐ Yes 2X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - America ck, White, et	
215-0036	hin 72 hou e. an "nature Medical E	Completed	15. Decedent's Education (Specify only highest grade con	1	16a. Deced (Give life. L	ient's Usual Occupat kind of work done di DO NOT use retired)	tion uring most of work	ing	16b. Kind of Bu		
12121	filed wil Hygien ther th		8th grade 17. Father's Name (First, Middle, Last)	na	Labo		50 Marks de Maria	(F) 14(14)	Nursi		ome
Maryland	₩ <u>a</u> b ≥	To Be	Jube Richardson				18. Mother's Nam Mary Ja			ne)	
Jary	2 shou and N is mar		19a. Informant's Name/Relationship (Type, P	rint)	19b. Mailin	ig Address (Street ar	-			State, Zip C	Code)
_	ss 1 and 2 should of Health and Men item 27 is marks other traumatic		Sarah Rives-Daugh			Pembrio			more i		21215
altimore,	Pages nent of int: If it		XXBurial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	ai iioiii State		sition (Name of natory or other place)					
Rait	permit. Pages Department of Important: If it any injury or once.		21. Sign turn of Funeral Service Licensee	X 2 / C	Ma	Memoria Name and Address rch F/H	of Facility West			W	
ı			23a. Partil. Enter the disease, or complication shock, or heart failure. List only one car	ns that caused the death.	Do not ente	OO Wabas or the mode of dying,	such as cardiac	Baltin or respiratory arre	nore Mo	A	L215 Approximate Interval Between
,	Pnysician		Immediate Cause (Final disease or condition resulting in death) a.	Confield	us.	Hear	Face	Pen			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as y conseque	ince of):	a leave	1	/		1	
	D H	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	rice of):	cury	100	aug-		10	T
,	icate be executed physician and the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	nce of);						
8/60,	icate be physicia s the bur	dicai	d				· · · · · · · · · · · · · · · · · · ·				
٥			IF FEMALE: 23c. If	yes, outcome of pregnance	ev .				004 Day		
.O. BOX	0 0 0	Physician/M	1 Ves 2 No	☐Live birth 2 ☐ Fetal do ☐Pregnant at time of dea ☐Unknown		Ectopic pregnancy Other (specify)			Mon	of delivery oth Da	ay Year
cords, r	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions contribut	ing to death but not resulti	ing in the un	derlying cause given	in Part I.	23e. Did tob			cause of death?
) 	The law ate has t page 2 s	Completed	- Employen					24a. Was an autopsy perform	r led2- de	/ere autopsyrior to compeath?	y findings available letion of cause of
Vital	ician: certific ector,	Be	25. Was case referred to medical examiner?	al:			26. Place of Death	(Check only one))		
10 10	iding Phys th. : After this () funeral dir	tion: To	1 192 \$ 2040	1 Inpatient 2 EF	Outpatient Bb. Time of Injury	28c. Injury a Work?	Nursing Hor	ne 5 Resider 28d. Describe hov	nce 6 Othe w injury occurre	r (Specify) id	
DIVISION	al or Atten s after deal if Director d in by the	ertification:	3 Suiside 6 Could not be	Place of Injury - At home building, etc. (Specify)	e, farm, stre			28f. Location (Stre City or Town,	eet and Numbe State)	r or Rural R	oute Number,
	To the Hospital or Attending within 24 hours after death. To the Funerat Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner: 0 all	To the best of my knowle in the basis of examination and manner stated.	edge, death n and/or inve	occurred at the time, estigation, in my opin	, date and place, a ion, death occurre	and due to the cau ad at the time, dat	use(s) and man te and place, ar	ner as state	e cause(s)
8	Mithi To ti	Ž	29b. Signature and title of certifier			29c. License n	number	29	d. Date signed	(Month, Day	v, Year)
	n	-	30. Name an address of person who complete	and cause of death the T	3a) /Tur = 0	1) d	3044	2	111 (0	ל כ	
_	5			27 / ///	оа) (туре, Р	NOS FEA	ep P	1 80	12 1	ad-(LL)
	Sta Registra	.6	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	6		*				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year William Thomas Brooks /Medical 12:30 p. .6 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 11 W. 20th Street Balto N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1**X** M 2 □ F Yrs. Director 218-44-4029 Md Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Modical Execution is used to mostlised any injury or other traumatic event, the Modical Execution. 10d. Inside City Limits Md N/A Balto Director XXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20th Street 11 W. 21218 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married ☐Yes 2X No Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 No Specify: \$ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Bethlehem Steel Elementary/Secondary (0-12) College (1-4or 5+) 9th grade N/A Welder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Brooks Mary McGowan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cassey Brooks - Daughter 5207 Frankford Avenue Apt H Balto, Md 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 6-9-2004 Catonsville, Md ^ 4 ☐ Donation _ 5 ☐ Other (Specify) Metro Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Balto, Md 21215 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 540,0 Gol /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Error Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medicai IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No ANGU has certificate 20No 1 Yes Division of Vital • Hospitel or Attending Physician: 24 hours after death. • Funerel Director: After this certifice in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Affesidence 6 Other (Specify) Hospital: ٩ 1 ☐ Yes 2 ☐ 1√0 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1-Watural er death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funerel C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) on Moure 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOU 2411 14 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 4 2004 Registrar

			1 - For State Registrar	State of Maryla		rtment of Health tificate of Deal			ene2001	18460
Т	Physici	an	1. Decedent's Name (First, Middle, Las		. 10			2. Date of Death Month	Qay Yea	3. Time of Death
	/Medic	al	LCRETTA 4a. Facility Name (If not institution, give		LING	4b. City, Town, or Location		Month	200 Yea	
	Examin	er	7406 Alvah Avenu 5. Social Security Number 6. S	ıe Apt A	s. last birthday)	Dundalk If Under 1 Year If Under		8. Date of Birth	Balt	imore
	Funeral Director			□M 2XIF 79	Yrs.	Months Days Hour	rs Min.	Month, Day, 1 Sept. 7,	1925 M	Sirthplace (State or Foreign Country) aryland
	pu *		Usual Residence of Decedent 10a, State 10b, County	10c. (City, Town or Lo	cation				10d. Inside City Limits
	72 hours atter death with the Maryland "netural", or Itams 23a or 28a-f show calcal Executer must be netitied at	tor	Maryland Baltin			ndalk				1 ☐ Yes 2X No
	or 28a-	Director	10e. Street and Number	nore	Dui	10f. Zip Code		100	. Citizen of What	Country?
	ath wit		7406 Alyah Ave	enue Apt A		21222			U.S.A.	
	ter des Itams	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No		Vas Decedent of Hispanic Yes, specify Cuban, Mexi	: Origin? (Spec rican, Puerto P	cify Yes or No- lican, etc.)	14. Race - Ar Black, Wi	nerican Indian, hite, etc.
20	hours after tural', or Ita	by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2☐XNo Spec	city:		Specify:	White
215-0036	in 72 ho "netur	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	(Give I	ent's Usual Occupation kind of work done during n	most of workin	9 16	b. Kind of Busines	
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<u>0</u>	filled Hygi other	Be Cc	12th. Grade 17. Father's Name (First, Middle, Last)		_ п(other's Name	(First, Middle, Ma	Own Hot niden Sumame)	ne
/land	d be enta Ked	To B	William	Granruth			Unkno	own		
Mar	S a se		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Nur	mber or Rural	Route Number, (City or Town, State	, Zip Code)
	Heal m 2		John Billing/Son		. Place of Dispos	ition (Name of		Baltimor	e MD 2	1222 or Town, State
Baitimore,	Pages nent of I int: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specific	Removal from State	cemetery, crem	atory or other place)	6/7/			
	permit. Pages: Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licer	Du.		 Crematory Name and Address of Fa 	acility		Laurel	MD
ñ	Der Imp		Whilling I Len	cet Moo 5	2/	Bradley-Asi 2134 Willow	hton-Ma w Spri	atthews	Baltimo	re MD 21222
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de one cause on each line.	ath. Do not ente					Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Anteriord	lewtic o	cardiovasen	lan d	weene		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):	Sanding Con	diama	. De a	10000	10 years
L	- ki	ler	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	equence of):	ZNINE GO	0,450,541		المستدن سو	7.0
	te be executed ysiclan and te burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c						
Ď,	e exe		resulting in death) Last	Due to (or as a conse	equence of):					
09/8	icate b physic s the b	dlcal		d						
BOX	The law requires that the death centificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg					23d. Date of d	lelivery
	death	Physician/M	in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
J.	res that the de signed by the a be detached to	Phys	9 Unknown					22a Did taba		to the same of death?
	signed	by	Part II. Other significant conditions of	ontributing to death but not r	esuiting in the un	derlying cause given in Pa	art I.			to the cause of death? Probably 4 Unknown
Records,	w require been si	ompleted	7,000,000					24a. Was an		autopsy findings available
Ř	The law	mp						autopsy	d? prior to	completion of cause of
Vital		O	25. Was case referred to medical			26. Pl	lace of Death	1 Yes 2 (Check only one)	No 1□Ye	es 2 No
ot <	d is	To B	examiner? 1 XYes 2 □ No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient	3□ DOA Other: 4□	Nursing Hom	e 5 X Residen	ce 6 □Other (Sp	necify)
	ing Ph		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		Bd. Describe how	injury occurred	
Division	l or Attending F after death. Director: After I in by the funeri	ertification:	2 Accident investigation 3 Suicide 6 Could not be		home farm stre	M 1 Yes 2		Rf. Location (Stre	et and Number or i	Rural Route Number,
<u></u>	after Direct	ertif	4 Homicide determined	building, etc. (Spe	cify)	ot, radioty, difficu		City or Town,		is a resident turns or,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	O	29a. Certifier 1 Certifying Ph	ysician: To the best of my k	nowledge, death	occurred at the time, date	and place, as	nd due to the cau	se(s) and manner	as stated.
	the H nin 24 the Fi	Medical	one)	and manner stated.	TIZCOTI ZILOVOT BIV					
•	5 1 1 S 1	~	29b. Signature and title of certifier T. Curstern	21	MD	29c. License number			Date signed (Moi	
	b		30. Name and address of person who		em 23a) (Type, I	Print)		3	Tune 4,	
_				lonovan, m	.0. 2	112 DUNDA	tlk 11	VE., B	ALTO /	10 21222
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature					
Dir	Registi	- 1	JUNI 4 2004	Beneva	6 1	or that				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 100 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year BEYER 0123 /Medical JUNE 2004 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□M 2🂢 F 212-20-5971 Director 78 July 19, 1925 Maryland Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene. ant: If item 27 is marked other then "natural", or Items 23a or 28a-f show 10a State 10b. Counts ir than "natural", or Items 23a or 28a-f show the Medical Exercipes must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 ☐ Yes 2 ☑ No Dundalk 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7413 Alvah Avenue Be Completed by Funeral 21222 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 X Widowed 4 □ Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) ementary/Secondary (0-12) 8th Grade College (1-4or 5+) Housewife Her own Home traumatic evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alexander Zalenzki 0 Josephine Banashak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Ebbert - Daughter 304 E. Belcrest Road Bel Air, Maryland other t 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 6/15/04 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ō permit. Page Department of Important: If any injury or once. * 4 ☐ Donation ¹⁵ ☐ Other (Specify) Balto Washington Cremation, Inc. Laurel Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bradley-Ashton-Matthews Funeral Home, Inc. 3a. Part. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, trainediate Cause (Final disease or condition). Approximate Interval Between Onset and Death **Physician** SEPSIS disease or condition resulting in death) DAYS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death Month Day Year Division of Vital Records, P.O. the 9□ Unknown Part II. Dthar significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MULTIOZGAN ISCHEMIC DISEASE Completed 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 R No 1 Alnpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To tha Funaral C

completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the h 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) I tall Guceley need MD RES-000 JUNE 11,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

ANN SHEEHY REED

JUN 1 4 2004

31. Date filed (Month, Day, Year)

32 Registrar's Signature

JOHNG HOPKING HOSPITAL TOWER 110 GOONCRTH WOLFE STREET MARYLAND 21287

BALTIMUZE

State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2:50 A M Frances P. Broches 06 09 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City. Town, or Location of Death Examiner 5606 Braxfield Road Arbutus Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Oct. 17,1916 5. Social Security Number 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Hours 1 ☐ M 2 💢 F Yrs. Oct. Director 87 Washington D.C. 217-22-5099 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show event, the Medical Examinar naut be notified at 1 ☐ Yes 2 📉 No Director MD Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 5606 Braxfield Road 21227 Completed by Funeral <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene Important: if Item 27 is marked other than "natural", or Item any injury or other traumatic event, it a Medical Exertendance. 1 X Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1 □ Yes 2X No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Social Security Administration College (1-4or 5+) Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Jules Broches Lillian Viola Ritter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Warren E. Harris / Godson 5606 Braxfield Rd., Arbutus, MD 21227 20b. Place of Disposition (Name of Meadowridge) 20a. Method of Disposition Date 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State ☐Donation 5 ☐ Other (Specify) 6-12-2004 Elkrid e MD Memorial Park 22. Name and Address of Facility Ambrose Funeral Home, Inc. Signatule of Funeral San 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus on each line? Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown page 2 should be detached for Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an this certificate 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 27 No 27. Manner of Pealth Other: 4 Nursing Home 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28d. Pes libe how injury occurred in by the funeral 28b. Time of Injury 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation death. 1 Tyes within 24 hours after dealt To the Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Indical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certified 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print) CHMA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 4 2004 Registrar

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	Exami		4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In yrs	:. last birthday)	Bo	alti,	Location o		Date of Birt		NA	
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	nd 2 shoulth and 27 is mu		19a. Informant's Name/Relationship (<i>Type, Print</i>) GAIL CHAPMAN-ROBINSON (MOTHER)		ng Address (WOO)		nd Numbei	r or Ru ra l Ri	oute Numbe	r, City or Tow	m, State, Zip	Code)
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			30. Name and eddress of person who	completed cause of death (Item	n 23a) (Type, Print)	71	a DA	0	7
			31. Date filed (Month), Day, Year)	32. Registrar's Signa	Zgle 1	DJ6907 Nursing	Teka	a ce	ner
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VARREN COVELLY

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29a. Certifier (Check only 200) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Ö	i i te	Serti	4 Homicide	building, etc. (Speci	fy)	,							
O.C.M.E. June 11, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		Hospit 24 hour Funere tely fille		29a. Certifier (Check only 2 Medical Examin	sician: To the best of my known: On the basis of examina	owledge, death ation and/or inv	occurred at	t the time	a, date and nion, deatl	d place, a	and due to the c	auso(s) an	d mannor ac et	atod
O.C.M.E. June 11, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		o the ithin 2 o the omplei	Med	X) (and manner stated.									
30. Name and address of perspn who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		⊢≯⊨ŏ		1 122	NAN					Ξ.				
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	•			30. Name and address of person who co	mgleted cause of death (Ite	n 23a) (Type. F	Print)							
State				JUNEAN W	1	111	Penn	Stre	et, I	Balt.	imore, M	Maryl	and 212	01
		Sta Registr		31. Date filed (Month, Day, Year)										

			1 - For		aryland / Depa		Health and	Mental Hy	giene ₂ ()	04	18467
			Registrar 1. Decedent's Name (First, Middle, Las	orl)		tineate of	Death	2. Date of De	Reg. No.		3. Time of Death
	Physici	an	1. Decedent's Name (1 #3t, Middle, La.					June 9,	Day	Year	
	/Media	cal	A. F. W. N	Martin	Benjamin				4c. County	-(D	7:15 P ^M
	Examir	ier	4a. Facility Name (If not institution, give			1	or Location of Deal	ın	,		0-
			7917 Trappe Road 5. Social Security Number 6. S		(In yrs. last birthday)	Dundal		Date of Big			re Co.
	Funeral			ex /. Age		Months Days		(Month, Da	h V. <i>Year)</i> 10,1943	9. Birthp	lace (State or Foreign try) yland
	Director		Usual Residence of Decedent		60 Yrs.			sept.	10,1945	Mai	y Tana
	and and		10a. State 10b, County		10c. City, Town or Lo	ocation				10	0d. Inside City Limits
	dary f sh	0	Maryland Bal	timore			Dundalk			1	1 ☐ Yes 2 🖾 No
	28a	ect	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Coun	try?
	with o	Funeral Director		ad Apt. B			2122	-	United		•
	eath	era	7917 Trappe Ro	12. Was Decedent I		Was Decedent of			14 Rac	e - Americ	an Indian
	lter d	Ë	1 Never Married 25 Married	Armed Forces? 1xxxes 2 □ N	lo	If Yes, specify Cub	Hispanic Origin? (S pan, Mexican, Puer	to Rican, etc.)	Blac	k, White,	
38	irs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify	" W	hite
215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show ite Medical Eva: in ar mast ke mailfied at	ed	15. Decedent's Ed	ducation	16a Dece	dent's Usual Occu	pation		16b. Kind of Bu	siness/Inc	Justry
15	n n	ple	(Specify only highest gra	de completed) College (1-4or 5	(Give	kind of work done DO NOT use retire	during most of wo	rking			
212	i the	Completed	Clementary/Secondary (0 12)	2 Years		b Driver			Atwate	er Cal	b Company
	Hygi other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Sumam	ie)	
a	Mental arked o	To B	Milton Dent					1	Mary Key	7S	
Maryland	SPEE	_	19a. Informant's Name/Relationship (Type, Print)			t and Number or R	ural Route Numbe	r, City or Town,	State, Zip	Code)
	and 2 salth a n 27 is		Mr. Kelly Dent	/ Son	7917	Trappe	Road Ap	t.B Du	ndalk,	Maryl	and 21222
Baltimore,	of Hear of Hear fitem		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other pla	ice)	Date	20c. Location -	City or To	wn, State
Ë			1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify				e Corp. 6	/11/2004	TOWCO	n Ma	red and
Ħ			21. Signature of Funeral Service Licer			2. Name and Addre		/ 11/ 200#	10050	II, Ma	TYTANG
B	permit. Departi Importa any inj		Volunte A	(m -	Di	ıda-Ruck	Funeral	Home of	Dundalk	, Inc	•
			23a Part1. Enter the disease, o com shock, or heart failure, sist only	plications that caused	the death. Do not en	er the mode of dyi	Ave Dui	n c or respiratory ar	ary Land- rest,	-212.	Approximate
	Dhusisian		Immediate Cause (Final	M A	Partit	4					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to or as	VIWVX - (\mathcal{M}	4.			-	111
	Examiner			Dag	In Taicm	PAM	horiha				2.M
4		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):	2007	Kunh	MUMM I	rigin		21
	sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ade	MOCALC	McMa.	monti	astinal	it damo	wh	2 <i>M</i>
ć	exec n and ial-tra	Exa	resulting in death) Last	Due to (or as	consequence of):	1	711900-1	200 11 1100	47470	1	
760,		cal		d							
89	eath certificate attending phy I for use as the										
Вох	nding use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		n=			23d. Dat	e of deliver	ry
m	death atte	ca	in the past 12 months? 1 ☐ Yes 2 ☐ No	1⊡Live birth 4⊡Pregnant at]Ectopic pregnanc] Other (specify) _	.у		Mor	nth I	Day Year
P.0.	that the de ed by the detached	Nys	9 Unknown	9□ Unknown							
	The law requires that the death certifica lie has been signed by the attending ph page 2 should be detached for use as th	by P	Part II. Other significant conditions of	ontributing to death be	it not resulting in the u	nderlying cause gr	ven in Part I.	23e. Did to	bacco use contr	ibute to the	e cause of death?
Records,	uires n sign	d b						1 □ Y	es 2□No	3 Proba	abiy 4 Unknown
Ö	w require been signal	Completed						24a. Was a	an 24b. V	Vere auton	sy findings available
Re	The lay	m d						autop: perfor	sy p med? d	nor to com	pletion of cause of
			OF Man and referred to medical							☐ Yes 2	2 No
Vital) Be	25. Was case referred to medical examiner?	Hospital:		0t	200	ath (Check only or		(0	
of		. To	1 ☐ Yes 2 X No 27. Manner of Death	1 ☐ Inpatie		IL SLI DOA	4 Nursing r	lome 5 Resid			,
O	ding Ph h. After th funeral	tlor	1 Natural 5 Pending	(Month, Day	Year) Injury	f 28c. Inju Wo M 1	rk?]Yes 2∐No				
S	Attending or death. ector: After by the fune	flca	3 ☐ Suicide 6 ☐ Could not be		iry - At home, farm, sti	eet, factory, office		28f. Location (S	treet and Numbe	er or Rurai	Route Number.
Division	after Olre	Certification;	4 Homicide	building, etc	(Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tow	n, State)		•
	splta ours neral filled		29a. Certifier 1 Certifying Ph	ysician: To the best of	if my knowledge, deat	n occurred at the ti	me, date and place	and due to the c	ause(s) and mai	nner as sta	eted.
	24 h 24 h e Fur etely	Medical	(Check only 2 Medicel Exert	niner: On the basis of and manner sta	examination and/or in	vestigation, in my	opinion, death occu	irred at the time, o	late and place, a	nd due to	the cause(s)
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Me	29b. Signature and tule of contifier	Osil V	A Hemitin	29c. Licens	se number	2	9d. Date signed	(Month, D	ley, Year)
	r > r ∪		VI VILLA HALLA	11/1/	, ,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1 1	8160		6/10/	2004	<i>f</i>
	150		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type	Print) -	4 100	A 0:0-	1 1		
	DIL		PETR HAUSNED . 2	2 South Gri	Deno Chort	, KD, Bul	Etimore M	0,21201			
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signatur	land		/			
	Registr		IIIN 1 4 2004	rengua	NO A	works					

			For State Registrar	State of		•		t of H	ealth a	and N	Mental Hy	Reg. No.	2004	18468	
	hysicia /Medic		1. Decedent's Name (First, Middle, Last) Mildred Dickerson								2. Date of De Month June	Day 9,	2004	3. Time of Death 11:00 p.M	
	Examin Funeral Director		4a. Facility Name (If not institution, give street and number) Genesis Hamilton Nursing Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs							е	4c. County of Deeth n/a 8. Date of Birth 9. Birthplace (State or Foreit			a	
1			5. Social Security Number 226-26-4529 6 Usuel Residence of Decedent	1□M 2X)F	97	Yrs.	Months				8. Date of Bin (Month, Di April 8,	1907	Po Tai	place (State or Foreign Intry) IC	
Maryland	e-f show	tor	10a. State 10b. County 10c. City, Town or Location 10d. Insid								10d. Inside City Limits 1 Y Yes 2 □ No				
n with the	23a or 28aust be not	Funeral Director	10e. Street and Number 3417 RoseTawn Avenue				10f. Zip Code 21214					10g. Citizen of What Country? USA			
1215-0036 within 72 hours after death with the Maryland ene.	Important: If item 27 is marked other than "naturel", or items 23s or 28e-f show sny injury or other traumatic event, the Medical Examinar must be natified at once.		11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricar 1 ☐ Yes 2 ☑ No Specify:					o- 14. Race - American Indian, Black, White, etc. Specify: White			
d 21215-0036 filed within 72 hours af Hygiene.	then "naturel", or the Medical Exami	Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed,	npleted) (Give		dent's Usual Occupation kind of work done during most of work DO NOT use retired) aker			ting		nd of Business/I	of Business/Industry		
Maryland 2 d 2 should be filed th and Mental Hyg	sarked other	8	17. Father's Name (First, Middle, Last) Ignatius Dzierzyk					18. Mother's Name (First, Middle, Ma Anna Gronko ing Address (Street and Number or Rural Route Number, C							
, Mar and 2 sho salth and	n 27 is m er traum		19a. Informant's Name/Relationship Frank G. Lidinsky/At			341	0 Whit	e Aver		ltimo	re Maryla	and 2	21214		
Baltimore, bermit. Pages 1 a Department of Hea	ant: If iten ury or oth		20a. Mathod of Disposition 1/☑ Burial 2 ☐ Cremation 3 3 4 ☐ Donation 5 ☐ Other (Spe		- 1	Place of Dispo cemetery, crer ington N	natory or c	ther place	9)	6/29	Date 9/04		ngton Vir		
Balt permit. Departr	Department Important: I eny injury o		21. Signature of Funeral Service Licensee Michael E. Canapp Leonard J. Ruck, Inc. Baltimore, M.												
/Me Exar	prician and pricial transit pricial and pricial transit pricial and pricial an	cai Examiner	23a. Part1. Enter the disease, or confiplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Interval Between		
I Records, P.O. Box 687 The law requires that the death certificate	ed by the attending physician and detached for use as the burial-transit	Completed by Physician/Medic	FEMALE: b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown								23d. Date of delivery Month Day Year				
rds, P.	should be detail	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown					
Records, The law requires t	rector, page 2 shou	complete									24a. Was auto perfo 1 Tes	autopsy prior to completion of cause of death?			
£ 5	this certifi al director	To Be	25. Was case referred to medical examiner? ¹ ☐ Yes 2 ☐ No 27. Manner gt Death ¹ ☐ Natural 5 ☐ Pending investigal	28a. Date (Mor	28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No								(y)		
Division To the Hospital or Attending 6 within 24 hours after death.	al Directo ad in by th	Certification:	3 Suicide 6 Could no 4 Homicide determine							28f. Location (Street and Number or Rural Route Number, City or Town, State)					
e Hospi	ne Funer pletely fills	Medical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.									stated. o the cause(s)			
To th within		Me	29b. Signature and title of certifier	and title of certifier (M.)				29c. License number D 31 4 6 4				29d. Date signed (Month, Day, Year)			
	10		30. Name and address of person who SHOAIIS A. H.	TSHMI	se of death (Ite	em 23a) (Type,	Print)	tw	ST 5	Smil	70E 3	Bo	Ut. m)21201	
©F	Stat Registra		31. Date filed (Month, Day, Year) JUN 1 4 2		Registrar's Sign	nature	Spi	reks	/						

		1	For State Registrar	State of Maryla	nd / Depa <i>Cei</i>	artment of H	ealth and N Death		ene 2 (004	18469
			Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day	Year	3. Time of Death
	Physicia /Medic		GEORGE ANTHONY	DIPIETRO,	SR.			JUNE	9, 2	2004	7:00 A.M
	Examin	er	4a. Fecility Name (If not institution, give str				Location of Death		4c. County		
			8511 OLD HARFORD RC			PARKV	LLE If Under 24 Hrs.	0. Date of Birth	BALT		Chate of Foreign
	Funeral		5. Social Security Number 6. Sex	4 2□F	. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,		Count	• '
	Director	-	218-07-3584 Usual Residence of Decedent	84				4/5/192	0	MARY	LAND
	/land		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10	d. Inside City Limits
	Mary	ţo	MD BALTIMOF	Œ	PAF	KVILLE					1 ☐ Yes 2 ☐ No
	death with the Maryland ms 23e or 28e-f show minual to codiffed at	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of V	What Count	ry?
	th wit	ai	8325 DALESFORD ROA	AD.		212	<u> </u>		USA		
	ems erm	iner	11. Marital Status	2. Was Decedent Ever in Armed Forces?	J.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- p Rican, etc.)		ce - America ck, White, e	
0	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give	_	1 ☐ Yes 2 ☐ No	Specify:		Specify		
Ś	be filed within 72 hours after death with the Maryla ital Hygiens than "naturel"; or Items 23e or 28e-f shot event, I're Medical Examicar must be codified at		3 ₹ Widowed 4 ☐ Divorced 15. Decedent's Educa	Year or Dates: WWI		dent's Usual Occup	ation	1	6b. Kind of B		HTTE ustry
Ç	n 72 n 72 n 72	Completed	(Specify only highest grade	completed)	(Give	kind of work done of DO NOT use retired	during most of wor			2011100001110	
7	within lene. then "	mo.	Elementary/Secondary (0-12) 12TH GRADE	College (1-4or 5+)	ALLIA	PAINTER			GMC		
ם פ	illed within Hygiene. other than	0	17. Father's Name (First, Middle, Last)		I. AUIC	/ LAINIEN	18. Mother's Nam	ne (First, Middle, M	laiden Suman	ne)	
<u> </u>		0 8	SALVATORE DIPIETRO				ANNA F	RUBINI			
	s 1 and 2 should f Health and Mer Item 27 Is marke other treumatic		19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailir	ng Address (Street	and Number or Ru	ral Route Number,	City or Town,	State, Zip	Code)
Ξ	alth a		LINDA MCNANEY	DAUGHTER		O1 DEVER	E LANE C	CATONSVIL			
ore	Pages 1 a ment of Hez ant: If Item ury or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re			sition (Name of matory or other plac			Oc. Location -		
Ĕ	nit. Pages bartment of cortant: If it injury or o		*4 □Donation 5 □Other (Specify)	PA		CEMETERY		2/2004	BALTI		
Ball	Departi Departi Importi eny inj		21. Signature of Funeral Service Licenses)/				E JOHNSON			
n	807 2 9		Mathe D	July		521 LOCH			SON, MI	212	Approximate
			23a. Part1. Enter the disease, or complications, or heart failure. List only one	ations that caused the dea cause on each line.	ath. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	SI,		Interval Between Onset and Death
1	Pnysician		Immediate Cause (Final disease or condition	0.4	11/						21611
	/Medical Examiner		resulting in death)	Due to for as a sone	quence of):						2901
		_	Sequentially list conditions, if any, leading to immediate	Due to (o as conte	Juenca of					-	-7 UP/
	ed sit	ine	cause. Enter Underlying	6	711)						1079)
	ate be executed nysician and he burial-transit	Examine	that initiated events c. resulting in death) East	Due to (or as a dense	equance of):	=				4	7.10010
9	siciar buris	ical E	d	ACA	tic	Clon	0(1				2901
89		b				50	0)				, , ,
ŏ	eath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnancy	,			te of delive	,
20		icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of 9 Unknown		Other (specify)			Mo	onth	Day Year
J.	at the de by the a	Physici	9 Unknown					00- 0144-5		1-1- 1- 1- 1- 1-	- and death?
_	The law requires that the te has been signed by th bage 2 should be detache	by F	Part II. Other significant conditions cont	ributing to death but not re	sulting in the u	inderlying cause giv	en in Part I.		acco use coni s 2□No	tribute to th 3 □ Proba	e cause of death?
ecords,	w require been si should t							1 1 10	s ZUNO	3 F1004	abiy conkriowii
e C	law rias be	Completed						24a. Was ar autopsy perform	,	Were autor prior to con death?	psy findings available apletion of cause of
<u> </u>		S							No	1 Yes	2□ No
Vital	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Oth	00	ath (Check only one		ister-	-in-law
0	hys this	2	1 Yes 25 No	28a. Date of Injury	☐ ER/Outpaties 28b. Time o	II 3LI DOA	4 🗆 Nursing n	lome 5 Reside			-in-law Residence
ח	ding P. h. After I	ion	1 SNatural 5 ☐ Pending	(Month, Day Year)	Injury	Wor	k? Yes 2⊡No		,,	97	
Division	deat deat ctor: / the	lical	3 Suicide 6 Could not be	28e. Place of Injury - At	home, farm, st			28f. Location (Str		ber or Rural	Route Number,
<u> </u>	= E # €	Certification:	4 Homicide determined	building, etc. (Spec	cify)			City or Town	, State)		
	spite	a O	29a. Certifier Physical Physics (1994)	ician. To the best of my k	ngwledge, deat	h occurred at the tir	ne, date and place	, and due to the ca	use(s) and ma	anner as st	ated.
	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	edicai	(Check only 2 Medical Examin one)	er: On the basis of examinand manner stated.	nation and/or in	ivestigation, in my o	pinion, death occu	irred at the time, da	ite and place,	and due to	me cause(s)
	To the To the comp	ž	29b. Signature and title of certifier	11 //		29c. Licens	e number	29	d. Date signe	d (Month, L	Day, Year)
7	()		MINI			04	445	6	6,00	0	14
Ţ	41			noteted cause of death (It			TOLICON	MD 2120	/ı		
	/			7600 OSLER I		SUITE 411	TOWNOIN,	I'IU AIAU	7		
	Sta Regist		31. Date filed (Month, Day, Year) JUN 1 4 2004	32 Registrar's Sig	& La	alle					

			For State Registrar	State of Marylar		rtment of I tificate of			C (2)	004 18470
			Decedent's Name (First, Middle, Last)					2. Date of Death	1	3. Time of Death
	Physici /Medic		Chauncey	W.		Lise	n hower	JUNE	10 2	2004 10:30 PM
	Examin Funeral Director	er	163-24-9196	Top Kin S HOS 7. Age (In yrs. 7. Age (In yrs.	iast birthday)_ Yrs.	Be I If Under 1 Year Months Days	or Location of Dea	8. Date of Birth	4c. County (of Death 9. Birthplace (State or Foreign Country) Mt. Wolf, PA
	pur A		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ly, Town or Loc	ation				10d. Inside City Limits
	Maryli f sho	or	PA York		rk					1 ☐ Yes 2√ No
	r 28m	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	
	23a o		2406 Amethyst Rd			1'	7404		USA	
036	be filed within 72 hours after deeth with the Maryland ital Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Enatrinar must be notified at	by Funerai		2. Was Decedent Ever in U Armed Forces? 1√2 Yes 2 ☐ No If Yes, Give Year or Dates:	lf	/as Decedent of I Yes, specify Cub	an, Mexican, Pue	Specify Yes or No- to Rican, etc.)		a - American Indian, k, White, etc. : White
aryland 21215-0036	within 72 ho ene. than "natur to Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give k	O NOT use retire	during most of wo d)	orking 1	6b. Kind of Bu	siness/Industry
2	ifiled withi Hygiene. other than		12		Instal	lation		me (First, Middle, M		communications
and		Be c	17. Father's Name (First, Middle, Last) Wilbert Z. Eiser	hower						θ)
2	should and Men is marke	٦ ک	19a. Informant's Name/Relationship (Typ		19b. Mailing	g Address (Street		lae Stopps ura <i>i Route Number,</i>		State, Zip Code)
Σ	1 and 2 s Health ar tem 27 is		Rozella M. Eisenhou	er/ Wife	2406 A	methyst	Rd York.	PA 17404		
timore,	permit. Pages 1 and 2 should Department of Health and Mer Importent: If Item 27 Is marke any injury or other traumatic once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	mount from State	Place of Dispos cemetery, crem	ition (Name of atory or other pla ematory	ce)			City or Town, State
Balt	permit. Depart Import any inj		21. Signature of Puneral Service License Matter		R	Name and Addre	on Funer	al Home T	050 Yor owson,	rk Rd MD 21204
j	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only off Immediate Cause (Final disease or condition resulting in death)	ations that caused the deat scause on each line. Is chemic	_	li Omyor		c or respiratory arre	st.	Approximate Interval Between Onset and Death
,8760,	ficate be executed I physicien and Is the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	Artery (uence of):	Disea	se			10 years
O. Box 68	To the Hospitel or Attending Physician: The law requires that the death certifics within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending pl recompletely filled in by the funeral director, page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of pregni 1 Live birth 2 Feta 4 Pregnant at time of c	ıl death 3 ⊟i	Ectopic pregnanc Other (specify)	у		23d. Date Mon	e of delivery th Day Year
ds, P.	uires that signed by	d by Ph	Part II. Other significant conditions control Dia betes mellitu		ulting in the un	derlying cause gr	ven in Part I.			ibute to the cause of death? 3 Probably 4 Dunknown
Division of Vital Records, P.O. Box	t: The law req icate has beer r. page 2 shou	Completed by						24a. Was an autopsy perform 1 \super Yes 2	DI	Vere autopsy findings available rior to completion of cause of eath?
₹	sicial s certifinecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient 2 🗆	ER/Outpatient	all DOA Ott		ath <i>(Check only one</i> Home 5☐ Resider		(6
ion of	nding Phy ith. : After this e funeral c	ation; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo	ry at rk? Yes 2 □ No	28d. Describe how		
Divis	s after dea bl Director ed in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specil	ome, farm, stre y)	et, factory, office		28f. Location (Stre City or Town,		er or Rural Route Number,
	he Hospil n 24 hour he Funere pletely fille	edical	29a. Certifier (Check only one) 1 ★ Certifying Phys 2 Medicel Exemin	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, death ation and/or inve	occurred at the trestigation, in my o	me, date and place opinion, death occ	e, and due to the car urred at the time, da	use(s) and man te and place, a	nner as stated. nd due to the cause(s)
	To the Comp	Ž	29b. Signature and title of certifier	M . I . I . D	Y.	29c. Licens				(Month, Day, Year)
	/\	1	·V	Medical Do			ES-000		June 1	0, 2004
-	154		30. Name and address of person who con JORPAN PAUTKIN, 60	O NORTH WOLFE	E STREET		no, BALT	IMOKE MA	RYLAND	31287
	Sta Registi		31. Date filed (Month, Day, Year) JUN 1 4 2004	22. Registrar's Signa	ature	land,				

			1 - For State Registrar	State of N	Maryland / Depa <i>Ce</i>	artment of F	lealth a Death	and Mental H	ygiene Reg. No.	2004	1847
	Physici		Decedent's Name (First, Middle, La Donald	Grey	Eastham			2. Date of D Month June		Year 2004	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, gi		,	4b. City, Town, o	_		4c.	County of Death	1
	Funeral Director		316-28-6026	Sex 7 1 M 2 F	Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under a Hours	8. Date of B Min. (Month, D May 8,	ay, Year)	COL	pplace (State or Foreign intry) tucky
	Maryland -f show	tor	Usuel Residence of Decedent 10a. State 10b. County Maryland Anne A	rundel	10c. City, Town or Lo	peation					10d. Inside City Limits
	with the	i Director	10e. Street and Number	A		10f. Zip Code 20724			10g. Citiz	zen of What Cou	intry?
036	s within 72 hours after death with the Maryland jiene. r than "natural", or itema 23a or 28a-f show The Medical Examiner must be notified at	by Funerai	371 Old Line 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 W Yes 2 [ff Yes, Give Year or Date:	□No		•	gin? (Specify Yes or N , Puerto Rican, etc.)	0- 1	14. Race - Ameri Black, White Specify:	
Maryland 21215-0036	d within 72 jiene. r than "na ire Medic	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12		(Give life.	dent's Usual Occup kind of work done o DO NOT use retired	during most d)	of working		nd of Business/Ir	ndustry
yland	should be filed nd Mental Hygi marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Las Arthur Omri Eas	tham			E1	r's Name <i>(First, Middle</i> Sie Iom Co	ffey	Sumame)	
Mar	and and		19a. Informant's Name/Relationship Elizabeth Easth			ng Address <i>(Street a</i> ld Line A		r or Rural Route Numb			
altimore,	Pages 1 and 2 nent of Health ant: if item 27 i		20a. Method of Disposition 1 Burial 2 Cremation 3 Community 4 Donation 5 Other (Special Community)	Removal from Sta	20b. Place of Dispo	sition (Name of matory or other plac	:6)	Date	20c. Loc	yland 2 cation - City or T	own, State
Balti	permit. Pages Department of Important: If ii any injury or once.		21. Signature of Funeral Service Lice	nsee	22	. Name and Addres	ss of Facility		eral	Home, T	nc.
· 法	Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each	sed the death. Do not ent line. c Encephalor		g, such as c	cardiac or respiratory a	arrest,	10	Approximate Interval Between Onset and Death I week
	/Medical Examiner		resulting in death)	Due to (or a	as a consequence of):						- WCCK
8760,	cate be executed physician and the burial-transit	dicai Examiner	Securitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	o-Pulmonary as a consequence of): osclerotic (as a consequence of):		cular	Disease			l week Years
.O. Box 68	the death certifi y the attending iched for use as	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)			23	3d. Date of delive	ery Day Year
Δ.	sign d be	by	Part II. Other significant conditions Diabetes Mell		but not resulting in the ur	nderlying cause give	en in Part I.			e contribute to the	he cause of death?
Vital Records,		Completed	Hypertension, Fibrillation	Cellulit	is, Sepsis,	Arterial		24a. Was auto perfo		24b. Were auto prior to co death? 1 \(\subseteq \text{Yes} \)	opsy findings available impletion of cause of
Vita	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 W No	Hospital:	tient 2 ER/Outpatien	Othe		of Death Check onl			
ion of	ding After fune	ertification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, E	jury 28b. Time of	28c. Injury Work	at at	sing Home 5 Resi 28d. Describe			у)
Division	ital or Attandris after deatling Director: led in by the	Certific	3 ☐ Suicide 6 ☐ Could not be determined	building,	njury - At home, farm, streetc. (Specify)			City or To	wn, State)		al Route Number,
	To the Hospitel or At within 24 hours after or To the Funeral Directompletely filled in by	le dical	one)	nysicien: To the bes niner: On the basis and manner	st of my knowledge, death of examination and/or inv stated.	estigation, in my op	oinion, deatr	place, and due to the occurred at the time,	date and p	place, and due to	the cause(s)
,	5 # 5 8 X	M	29b. Signature and title of certifier	6/	mon mon	29c. License	number 5422			signed (Month,	•
	10		30. Name and address of person who Robert Magein,		death (Item 23a) (Type, I	Print)		Maryland 2		20	,,,,
	Sta Registr	6	31. Date filed (Month, Day, Year) JUN 1 4 2004		trar's Signature	books			, ,		

			1- For State of Maryland /	Department of Health and Mental Certificate of Death	Hygiene Reg. No. 2004 18472
	Physici /Medi Examir	al	1. Decedent's Name (First, Middle, Last) Linds Cy Fike 4a. Facility Name (If not institution, give street and number) University of Madeul Cond Medic	4b. City, Town, or Location of Death	1 1 4 4 1 1 1 1 1
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 1 M 2 X) F Usual Residence of Decedent	Months Days Hours Min. (Mon	of Birth (Day, Year) 18, 2003 9. Birthplace (State or Foreign Country) Maryland
	death with the Maryland ms 23a or 28a-f show	ector	10a. State 10b. County 10c. City, To MD Harford Fore	own or Location	10d. Inside City Limits 1 ☐ Yes 2 🂢 No
	eath with the ns 23a or 2	Funeral Director	10e. Street and Number 308 Bynum Ridge Road 11. Marital Status 12. Was Decedent Ever in U.S.	10f. Zip Code 21 050	United States or No- 14. Race - American Indian.
5-0036	or ita	by	1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et 1 ☐ Yes 2 □ XNo Specify:	Black, White, etc. Specify: White
21215-(d within piene. r than "	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	6a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Maryland	s 1 and 2 should be filed if Health and Mental Hygin Itam 27 is markad other other traumatic event, II	To Be C	17. Father's Name (First, Middle, Last) Richard Alan Fike	18. Mother's Name (First, N Kathleen Nob	diddle, Maiden Sumame) ole Smith
	es 1 and 2 sl of Health and f itam 27 is r r othar traur	2.	Richard Alan Fike/father 3	9b. Mailing Address (Street and Number or Rural Route No. 18 Bynum Ridge Road, Forest of Disposition (Name of tery, crematory or other place)	
Baltimore,	permit. Pages Department of Important: if i any injury or once.			Air Mem. Gardens 06/15/20	owson Funeral Home, Inc.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	e of):	ory arrest, Approximate Interval Batween Onset and Death
8760,	ate be executed hysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence d.	9 OT):	drame
P.O. Box 68	death certific e attending pl d for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death	th 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
	The law requires that the de tite has been signed by the a bage 2 should be detached f	þ	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
al Rec		e Completed	25. Was case referred to medical	101	
Division of Vital Records,	ding Phy. After this funeral d	ToB	examiner? 1 Yes 2 No Hospital: Inpatient 2 ER/O	Time of Injury M 28d. Injury at Work? 1 \(\triangle \text{Yes} \) Yes 2 \(\triangle \text{No} \)	Residence 6 Other (Specify) ribe how injury occurred ion (Street and Number or Rural Route Number.
Ō	To the Hospital or Attano within 24 hours after death To the Funeral Director: completely filled in by the	edical Cert	29a. Certifier Certifying Physicien: To the best of my knowled	ge, death occurred at the time, date and place, and due to and/or investigation, in my opinion, death occurred at the t	or Town, State) the cause(s) and manner as stated. time, date and place, and due to the cause(s)
)	To the within 7 To the comple		29b. Signature and title of certifier Picio	29c License number	29d. Date signed (Month, Day, Year)
	3		30. Name and address of person who completed cause of death (Item 23a	(Type, Print) 22 South Gree	ne Street Baltingery
	Sta Registr	-	JUN 1 4 2004 Seperal Signature	Sporth	

			1 - For State Registrar	State of Maryla		ent of Health and ate of Death		jiene •g. No. 200	4 18473
2	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, La White Am 4a. Facility Name (If not institution, given the Community of the Community	John e street and number) OPKINS HOSE	HA1 15	ADUSKI ty, Town, or Location of De A HIMDRE	2. Date of Deat Month JUNG		3. Time of Death 11.54 M
	Funeral Director		217-64-4898	// /	. /ast birthday) Mont	der i Year 11 Under 24 H	n. (Month, Day,	, Year) 9. Bi	rthplace (State or Foreign ountry) Ohio
	e Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland N/A	10c. C	Baltimore				10d. Inside City Limits 1 X Yes 2 □ No
21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. See I show mental the marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at proce.	leted by Funeral Director	10e. Street and Number 5615 Boxhill Lat 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Expectify only highest gray	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes = (M)No If Yes, Give Year or Dates:	U.S. 13. Was Oe If Yes, 1 □ Ye 16a. Decedent's U. Give kind of	Zip Code 21210 cedent of Hispanic Origin? specify Cuban, Mexican, Pu s 2 X No Specify: sual Occupation work done during most of w Tuse retired!	(Specify Yes or No- arto Rican, etc.)	0g. Citizen of What C U.S.A 14. Race - Am Black, Whi Specify: 16b. Kind of Business Health Cai	encan Indian, te, etc. White
N	filed within Hygiene. other than ent, Ille We	e Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last,	College (1-4or 5+) 5+	Archit	ect	ame (First, Middle, M	Institutio	-
aryland	should be and Mental is marked o	To Be	Lawrence F. 19a. Informant's Name/Relationship (Grabowski	19b. Mailing Addr	Garne ess (Street and Number or		nor Englui ; City or Town, State,	
Σ	es 1 and 2 of Health a fitem 27 is r other tra		Elizabeth B. Gra 20a. Method of Disposition 1 Burial 2 Termation 3 D	20b.	5615 Box Place of Disposition (cametery, crematory)	Name of	altimore,	Maryland 20c. Location - City or	21210 Town, Stete
	permit. Peges Department of I Importent: If it ony injury or o		21. Signature of √ ve al Service Licer	∅ Hi	22. Name	ice Corp. 6-1 and Address of Facility RI O York Road	uck Towson	Towson Funeral H Maryland	Maryland Home, Inc. 21204
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart faifure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the dea	ath. Do not enter the n	node of dying, such as card			Approximate Interval Between Onset and Death
1760,	ite be executed sysician and ne burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse	odence of):	ind Rome			5 YEARS 43 YEARS
.O. Box 68	Attending Physicien: The law requires that the death certifica redeath. redeath ar death ar death er this certificate has been signed by the attending phetor. After this certificate has been signed by the funeral director, page 2 should be detached for use as the funeral director.	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 ☐Ectopic	c pregnancy (specify)		23d. Date of de Month	livery Day Year
rds, P	quires that n signed b uld be deta		Part II. Other significant conditions of	ontributing to death but not re	sulting in the underlyin	g cause given in Part I.	23e. Did tob	pacco use contribute to es 2 □ No 3 □ P	o the cause of death?
I Record	The faw requir cate has been si page 2 should	Completed					24a. Was ar autops perform 1 \(\text{Yes} \) 2	v prior to	utopsy findings available completion of cause of
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospitaf:		Other	eath (Check only one		
ou of	ding Phys	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury	28c. Injury at Work?	Home 5 Reside	ince 6 Other (Spe w injury occurred	ocify)
Division of	To the Hospitel or Attending Ph. within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined				28f. Location (Str City or Town	reet and Number or R i, State)	ural Route Number,
	To the Hospitel or within 24 hours afte To the Funeral Dir. completely filled in I	Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of my kn niner: On the basis of examin and manner stated.	nowledge, death occurr ation and/or investigat	ed at the time, date and pla ion, in my opinion, death oc	ce, and due to the ca curred at the time, da	use(s) and manner as ate and place, and due	s stated. e to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	1-10		29c. License number	29	9d. Date signed (Mont	th, Dey, Year)
•	25		30. Name and address of person who	compl se of death (Ite	om 23a) (Type, Print)	BAHIMUNE,	m · ·) UNE 11	, 2004
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	E STEET	PHITIMONE,	MARY LANC	1 2/28	

			Registrar	State of Maryland	/ Departme <i>Certifica</i>	nt of Hea te of De	alth and I eath		Reg. No.	2004	18	474
	Physicia	an	Decedent's Name (First, Middle, Last)	- 1		Q 5	l	2. Date of De Month	Day	Year		e of Death
	/Medic	cal	Sadie 4a. Fecility Name (If not institution, give s	Rebecca		Gunt	ner cation of Death	June	9	2004 County of Deat	5:5	5a. ™
	Examin	er	6734 Fox Meadow	_		ltimo			40.0	ounty or Deat	"	
_	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		er 1 Year If	Under 24 Hrs. Hours Min.	8. Date of Bi	rth	9. Birt	hplace (Stat	te or Foreign
	irector		212-01-1482	^{M 2} ₹ 90	Yrs.	s Days	nours wiri.			13	MD	
and	*		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location						10d. Inside	City Limits
Maryl	fsho	jo	MD N/A	Pal t	timore							es 2 □ No
the r	r 28a	rect	MD N/A 10e. Street and Number	Dali		Zip Code	-		10g. Citize	en of What Co	untry?	
th with	23a o	ai D	6734 Fox Meado	w Road		2120	7		ζ	J.S.A.		
r dea	ems er ma	Funeral Director	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13. Was Dec			pecify Yes or No o Rican, etc.)	0- 14	4. Race - Ame Black, White		,
s afte	, or It	by F.	1 ☐ Never Married 2 ☐ Married **Divorced	1 ☐ Yes ৡ∑ No If Yes, Give Year or Dates:			Specify:			Specify:		
Pour :	sal Es	ed b	15. Decedent's Educ		16a. Decedent's Us	sual Occupatio	n		16b. Kind	B I d of Business/	.ack	
hin 72	Medic Medic	piet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give kind of the life. DO NOT	vork done duri use retired)	ing most of wor	rking			,	
od wit	grene er the	Completed	llth grade	na	C1	erk			Ship	pping	Comp	any
be filed within 72 hours after death with the Maryland	and Mental Hyglene. is marked other than aumatic event, the Ms	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle	, Maiden S	lumame)		
should	narke narke	2	19a. Informant's Name/Relationship (Typ	Barnette	19b. Mailing Addre			Cooper	0%	Taura Chaha S	7:- O- d-1	
d 2 s	I Health and Mealta I Hygene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at		Carolyn Cornick	Grand	6734 F	,			•			1207
2 - C	f Hea item (20a. Method of Disposition	20b. Plac	ce of Disposition (A		1	Date		ation - City or		
Page C	nt: If ry or		XXBurial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donetion 5 ☐ Other (Specify)	HIOVAI HOIH State	dlawn Ce		v 6/1	5/04	Balt	timore	Co	Md
illi.	Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funeral Service License	e 1/ 1		and Address o		-, -				
3 8	2 = 2 9		1 Klynn 7	Meke	4300	Wabas	sh Ave	Balt		e Md	2121	5
		П	23a. Parl1. Enter the disease, or complice shock, or heert dilure. List only on			ode of dying, s	such as cardiad	or respiratory a	arrest,		Approxin Interval I Onset ar	Between
	ysician Jedical	Н	Immediate Cause (Final disease or condition resulting in death)		helmers	D	emer	ra				eaks
	aminer			Due to (or as a conseque	nce of):							
Щ.		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	nce of):							
cuted	ınd transi	Examiner	Cause (Disease or injury that initiated events cresulting in death) Last									
5 6 6	cian a	EX	resulting in death) cast	Due to (or as a consequen	nce of):							
The law requires that the death certificate be executed	g physician and as the burial-transit	edicai	_ d	•								
certif	nding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnanc					23	d. Date of deli	very	
death	e atte	icia	in the past 12 months? 1 ☐ Yes 2 No	1 Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of dea						Month	Day	Year
at the	by th	Physician/M	9 Unknown	9□ Unknown								
res th	been signed by the attending should be detached for use a	Ď	Part II. Other significant conditions con	tributing to death but not resulti	ing in the underlying	g cause given i	n Part I.		tobacco use Yes 2□	e contribute to		of death?
requir	een s hould	Completed						-				
e law	2 5	mpl						24a. Was auto		24b. Were au prior to death?	topsy finding completion o	as available of cause of
1 H	s certificate has birector, page 2 s		25. Was case referred to medical				2 01	1 ☐ Yes	2 No	1 🗆 Yes	2 🗆 No	
/slcia	s certi	o Be	eveminer?	ospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatient 3	Other	4 Nursing H	ome 5 Resi		Other (Spec	eifv)	
5 a	ter thi	n: T	27. Manner of Death		8b. Time of Injury	28c. Injury at Work?		28d. Describe			,,	
end in	eath. or: Af he fur	atlc	1 Natural 5 Pending 2 Accident investigation		М		2 □ No					
or Att	iter de Directi in by t	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, fact	ory, office		28f. Location (City or To	Street and wn, State)	Number or Ru	ral Route N	umber,
pital C	within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	O	29a, Certifier 1 Certifying Phys	icien: To the best of my knowle	edge death occurr	ed at the time	date and place	and due to the	C31160(6) 31	nd manner as	stated	
e Hos	• Fun letely	edical	(Check only 2 Medical Examin	er: On the basis of examination and manner stated.	n and/or investigati	on, in my opini	on, death occu	rred at the time,	date and p	lace, and due	to the cause	e(s)
To th	Withir To th comp	Me	29b. Signature and title of certifier	0 1	2	9c. License nu	umber Ma	youd		signed (Month		
			> Kokert (Mulle	MO	DA	1523	4	JUNG	211,	200	14
1	0		30. Name and address of person who to	mpleted cause of death (item 2	(Type, Print)	Ing Ea	of So	re c	ator	211, nsvilke Maryla	11 -	2/228
	Sta	10	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	(0)	/	- 2	UY		maryla	ucl	
	Registr		解解 7 4 2004	General 19	Ann.	10				,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** GAMPEL JUNE 9 2004 11:20A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTO. - GILCHRIST CENTER TOWSON

If Under 1 Year If Under 24 Hrs. BALTIMORE 8. Date of Birth (Month, Day, Year) AUG 27, 1 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) Funeral Min. Days 1□M 2□F Months Hours NEW YORK 1926 Director 133-14-1552 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f shov 1 Yes 2 No Directo N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3401 HATTON RD. 21208 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Slatus 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 Married WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **JOSEPH** WEISER IDA MALIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) GEORGE GAMPEL (HUS.) 3401 HATTON RD. BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages 'Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State SHAAREI TFILOH 6/11/04 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Tola 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death dee Cancer mmediate Cause (Final Physician . a Months disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician er s the burial-t Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the pasi 12 months?
1 Yes 2 2040 Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 🗆 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence Other (Specify) NOS PICE 2 1 ☐ Yes 2 ☑ No this After the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Jeath 28b. Time of 28d. Describe how injury occurred Certification: 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours e Funeral C 29a. Certifier 1) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

State Registrar

n

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Ijem 23a) (Type, Print)

ACCOMPANDED TO THE COMPANDED TO THE COM 32. Registrar's Signature

within 2 To the I To the

29d. Date signed (Month, Day, Year)

June 9 2004

rades Baltmanz NP 21204

			1 - For State Registrar	State of Marylan		artment of H tificate of L		Re	g. No. 200	4 18476
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Martha Noinette H					2. Date of Death Month	Day Year	M
	Examin	er	4a. Facility Name (If not institution, give s Edenwald			4b. City, Town, or Tows	on		4c. County of De	imore
	Funeral Director		5. Social Security Number 217-16-3387 6. Sex	7. Age (In yrs.)	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rear) (irthplace (State or Foreign Country) Cyland
	e Maryland ta-f show	ctor	10a. State 10b. County MD Baltimore	10c. City	y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 X No
	ath with th 23a or 24 ust be n.	Funerai Director	800 Southerly Road	d Unit 1515		10f. Zip Code 21286			Og. Citizen of What C	
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. I proportent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at once.	þ	11. Marital Status 1 Never Married 2 Married 3 Xiolidowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ∐Yes 2 ሺ No If Yes, Give Year or Dates:		Vas Decedent of Hi f Yes, specify Cubai I ☐ Yes 2 🛛 No	spanic Origin? (s n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify:	
21215-0036	d within 72 ha giene. Ir than "natu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Deced (Give life. I	lent's Usual Occupa kind of work done of OO NOT use retired,	ation luring most of wo)	orking 1	6b. Kind of Busines Own Home	s/Industry
Maryland :	ould be filed Mental Hyg Parked othe	To Be C	17. Father's Name (First, Middle, Last) Charles H. Diehl				Frieda M		,	
e, Mar	and 2 sh fealth and im 27 is in her traum		19a. Informant's Name/Relationship (Ty) Lawrence Rackson	/ friend	17 A1:	ston Road sition (Name of		rville, N	City or Town, State, D 21093 Oc. Location - City o	
Baltimore,	. Pages 1 Iment of H tent: If ite jury or ot		20a. Method of Disposition 1 □ Burial 2 🖾 Cremation 3 □ R 1 □ Donation 5 □ Other (Specify)	emoval from State	emetery, crer 1 top So	ervice Co	rp. 6/19		owson, ME)
Bal	permit Depar Impor any in		21. Signature of turning Service License	my_	R	. Name and Addres	n Funera			MD 21204
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Due to (or as /conseq	b dynuence of)	plasty	Lysen Lysen	home	st,	Approximate interval Between Onset and Death
8260, 米	death certificate be executed e attending physician and ad for use as the burial-transit	dical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							,
O. Box 6	death certiff e attending ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
ds, P.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did toba	A	to the cause of death? Probably 4 Unknown
Vital Records,	The ate h page	Completed						24a. Was an autopsy perform 1 Yes 2	ed? prior to death?	autopsy findings available completion of cause of
ot	Attending Physician: The death. sctor: After this certificate by the funeral director, pag	tion; To Be	25. Was case referred to medical examiner? 1 Yes 22 No 27. Mann Death 1 Actural 5 Pending investigation	lospital: 1 Inpatient 2 Inpati	ER/Outpatier 28b. Time of Injury	28c. Injury Work	er: 4 Viursing	ath (Check only one Home 5 Resider 28d. Describe how	nce 6 Other (Sp.	ecify)
Division	ial or Attences after death	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, str y)	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or F State)	Rural Route Number,
	To the Hospital or At' within 24 hours after d To the Funeral Direct completely filled in by	Medical (sicien: To the best of my kno ner: On the basis of examina and manner stated.						
r	To the within To the comple	Σ	29b. Signature and title of certifier	m N	bource	29c. License	number 297	69	d. Date signed (Mon	104
	8		proruling D.	ompleted cause of death (Item	- 4	Print) 5 /	6 n.	ep/lax/	2 BA	14 2/228
	Sta Registi		31. Date filed (Month, Pay, Year) JUN 1 4 2004	32. Registrar's Signa	(ure	rake		0		

			1 - For State Registrar	State of I	Maryland / Depa	artment of H			giene Reg. No.200	4 18477
	Dhysisi		Decedent's Name (First, Middle, Las	t)				2. Date of De Month		3. Time of Death
	Physici /Medi		Tatsuo	Hase					9, 2004	11:36am M
3	Examir	ner	4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Dea	ath	4c. County of	Death
			Laurel Regional			Laurel				ce George
	Funeral		Social Security Number 6. Security Number	x 7. X M 2□F	Age (In yrs. last birthday) 7.6 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	n. (Month, Da	rth ay, Year)	Birthplace (State or Foreign Country)
	Director		103-30-9723 Usual Residence of Decedent		76 Yrs.			April	1, 1928.	Japan
	and and		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	darylan f ehow	ō	Maryland Prince G	leorge	Laure1					1 TYYes 2 □ No
	28a-	ec	10e. Street and Number	COLSE	Laurer	10f, Zip Code			10g. Citizen of Wha	it Country?
	with Sa or	ā	8713 Oxwell Lane			20708	₹	,	U.S.A.	,
	within 72 hours after death with the Maryland one. then "neturel", or items 23a or 28a-1 ehow he Madical Exar it at reast ke notified at	Completed by Funeral Director	11. Marital Status	12. Was Decede	nt Ever in U.S. 13.			(Specify Yes or No orto Rican, etc.)		American Indian,
(0	riter of	F	1 ☐ Never Married 2 ☑ Married	Armed Force	TINO			erto Rican, etc.)		White, etc.
036	el', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Date		1□Yes 2∰ No	Specify:		Specify:	Asian
21215-0036	72 ho	ted	15. Decedent's Edi (Specify only highest grad			dent's Usual Occup		ndkina	16b. Kind of Busin	ess/Industry
21	thin 7	npie.	Elementary/Secondary (0-12)	College (1-4	life.	DO NOT use retired	d)	orking .	U.S. Gov	ernment
2	od wi	ő		8+	P.	athologis			WRAIR	
pu	d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,	, Maiden Surname)	
yla	Menid barke	ဂ္	Setsu Hase				Suga			
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Maryla nt of Heatth and Mental Hygiene. If item 27 is marked other then "neturel", or items 23a or 28a-1 ehow or other treumetic event, the Madical Exertities is printed by profiled at		19a. Informant's Name/Relationship (T						er, City or Town, Sta	te, Zip Code)
2	and ealth m 27			ife)		3 Oxwell	Lane, La		Maryland	20708
ore	of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I	Removal from Sta	10	natory or other plac	1	Date	20c. Location - City	y or Town, State
Ē	Pag ment ent: jury		¹ 4 □ Donation 5 □ Other (Specify))	Balt/Was	sh. Crema			Laure1,	Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other trei		21. Signature of Funeral Service Licens	/	01250	Name and Addre	ss of Facility F	leck Fune	eral Home, cel, Maryl	Inc.
	1 2 1		23a. Part1. Enter the disease, or comp	lications that caus	sed the death. Do not ent					Approximate Interval Between
	Filmonto to an		shock, or heart failure. List only of Immediate Cause (Final			D.				Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	ronary Arter	y Diseas	e 			2 Years
	Examiner			D00 10 (01	as a consequence on.					
		ē	Sequentially list conditions, it any, regularly to immediate	b. Qualto (or	as a consequence of):				~	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
Ć,	be executed sician and burial-transit	Еха	resulting in death) Last	Due to (or	as a consequence of):					
8760,	icate be ex physician s the buria	dical		d						
68	ificate g phys as the	edi								
Вох	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor		1 			23d. Date of	delivery
	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant	at time of death 5]Ectopic pregnancy] Other <i>(specify)</i>	<u> </u>		Month	Day Year
0	that the de led by the a detached t	hys	9 Unknown	9□ Unknowr	1					
<u>d</u>	res tha igned to be det	by P	Part II. Other significant conditions co	ntributing to death	n but not resulting in the u	nderlying cause giv	ел in Part I.	23e. Did to	obacco use contribut	e to the cause of death?
Records,	quire in sig uld b	pa	Ischemic Cardio	omyopathy	7			101	Yes 2□No 3□	Probably 4* Unknown
8	s been s	Completed						24a. Was	an 24b. Wer	autopsy findings available
Re	The lav	E O					,		rmed? deat	to completion of cause of h? Yes 2 No
Vital		a)	25. Was case referred to medical				26. Place of De	eath (Check only o		163 20110
<u>></u>	S S	0.0	examiner? 1 Tes 2 No	Hospital:	atient 2 ER/Outpatien	t 3 DOA Oth			dence 6 Other (Specify)
of		n:T	27. Manner of Death	28a. Date of I	njury 28b. Time of Injury		y at		how injury occurred	
ion	utending death. ctor: Aft y the fun	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(MOIIII), I	Day (Gai) Injury		Yes 2 □ No			
Division	l or Attending after death. Director: Afte I in by the fune	ific	3 ☐ Suicide 6 ☐ Could not be determined	280. Place of	Injury - At home, farm, str	eet, factory, office		28f. Location (S City or Tox		r Rural Route Number,
Ö	el or Att s after d el Direct ed in by	Certification:	4 E Homorov	building,	etc. (Specify)			Only of You	, ((()	
	To the Hospitel within 24 hours a To the Funerel Completely filled	Medical ((Check only 2 Medical Exam	iner: On the basis	st of my knowledge, death of examination and/or in	occurred at the tin vestigation, in my o	ne, date and place pinion, death occ	e, and due to the curred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	thin 2 the mple	Med	one) 29b. Signature and title of certifier	and manner	siateu.	29c. Licens	e number		29d. Date signed (M	onth Day Year)
	7 × 100		200. Orginatoro arromitato continuo	11.	-		26443			
	~		1/d fr	wer	10)		-0443		June 9,	2004
	1.8		30. Name and address of person who c Gregory H. Fishe	er, MD 15	225 Shady G	Print) rove Rd.	Rockvil	1e, MD 20	0850	
Г	Sta		31. Date filed (Month, Day, Year)	32. Regi	strar's Signature	boals				

			1 - For State Registrar	State of Ma		artment of		nd Mental Hyg	iene •g. No2 () () (18478
	Physici	an	Decedent's Name (First, Middle, Last	1/2016				2. Date of Dea Month	Day Year	
1	/Medi Examir		4a. Facility Name (If not institution, give Southern Maryland	tyoll street and number) Hospita	P	Clin			4c. County of De	eorges.
	Funeral Director		5. Social Security Number 6. S 579-26-3082 Usual Residence of Decedent	ex 7. Age	79 Yrs.) If Under 1 Ye Months Day		Min. 8. Date of Birth (Month, Day, April	9. 8 9, 1925 Was	orthplace (State or Foreign Country) hington, D.C
	ith the Maryland or 28e-f show	Olrector	10a. State 10b. County Maryland Anne Aru 10e. Street and Number	ndel	10c. City, Town or L Lothian	10f. Zip Cod	е	1	0g. Citizen of What C	10d. Inside City Limits 1 □ Yes 2 □ → Country?
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene term 27 is marked other then "netural", or items 23e or 28e-f show other treumatic event. The Medical Examiner must be notified at	tby Funeral Director	211 5th Street 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	Ever in U.S. 13.		-	n? (Specify Yes or No- Puerto Rican, etc.)	U.S.A. 14. Race - Am Black, Wh Specify:	
21215-0	within 72 he lene. then *netu	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5-	+) (Give		cupation ne during most o tired) etal Wor	of working	16b. Kind of Busines Contracti	·
Maryland 2	should be filed ind Mental Hygid marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) Harry Hyatt					s Name (First, Middle, M		
Baltimore, Mary	9 = 5 0 = 5		#9a. Informant's Name/Relationship (7) Sharon Anderson 20a. Method of Disposition 1	(Daughter	20b. Place of Disposemetery, cre	Kalmia osition (Name of matory or other p	Drive,		aryland 20 20c. Location - City o	707 r Town, State
Balti	permit. Pa Departmen Importent: eny injury		21. Signally of Fureral Service Light	99 0	2	2. Name and Ad	dress of Facility	Fleck Funer g Road, Lau	al Home,	Inc.
	Physician		23a. Part1. Enter the disease, or composition shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line	the death. Do not ene. Anythy a consequent of):		dying, such as ca	ardiac or respiratory arre	est,	Approximate Interval Between Onset and Death
8760,	Medical Examiner whysician and the purial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate English that Cause (Disease or injury that initiated events resulting in death) Last	b. there ten Due to (or as a	•					years.
P.O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	2 Fetal death 3	□Ectopic pregnal □ Other (specify)			23d. Date of de Month	llivery Day Year
	quires that n signed b uld be deta	by	Part II. Other significant conditions of	_	_	inderlying cause	given in Part I.		_	o the cause of death?
I Reco	The ate h page	Completed	Congestion	e Heart Jes	ilene			24a. Was ar autopsy perform 1 \(\text{Yes} \) 2	/ prior to	utopsy findings available completion of cause of
Division of Vital Records,	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate completely illed in by the funeral director, page.	tlon; To Be	27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatien 28a. Date of Injury (Month, Day	28b. Time o	f 28c. ln	Other: 4 Nursi	Death (Check only one ing Home 5 Teside 28d. Describe ho	nce 6 Other (Spe	ecify)
Divisi	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injurbuilding, etc.		reet, factory, offic	Ce Ce	28f. Location (Str. City or Town		
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Aedical	(Check only 2 Medical Exam	ysician: To the best of tiner: On the basis of e and manner state	examination and/or in	vestigation, in m	y opinion, death	place, and due to the ca occurred at the time, da	te and place, and du	e to the cause(s)
	To To Con	Σ	29b. Signature and fittle of certifier	>			ense number		d. Date signed (Moni	
	10X,		// M //-	completed cause of de		Print) Cle	inton a	ud 2073	5	
l	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 4 2004	32. Registrar	r's Signature	bach				

			For State	State of Marylan		artment of F		Mental Hy	giene Reg. No. 2	nnı	181.79
	172.70		Registrar 1. Decedent's Name (First, Middle, Last)			tineate or	Doutin	2. Date of De		. 0 0 %	3. Time of Death
	Physici /Medic	_	ELIZAG	BETH	HARI	EYMAN		June	9 Day	2004	215 AM
	Examin	-	4a. Facility Name (If not institution, give s				or Location of Dea	th		unty of Death	4
			/ /	JWOOD AU			RLEA If Under 24 Hrs	0 Data -(B)		BALTI	
	Funeral Director		217-16-1371	M 217 F 7. Age (In yrs.	Yrs.	Months Days	Hours Min		1921	9. Birthpi Coun	lace (State or Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				11	0d. Inside City Limits
	Maryl f sho	lor	MD BALTI	More		OVERIE	* A				1 Yes 2 No
	r 28a	Director	10e. Street and Number			10f. Zip Code	. 7		10g. Citizen	of What Coun	try?
	th with		4305 Kenwal	D AVE		2	1206			U.S. F	7.
	ems er m	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of I	dispanic Origin? (S an, Mexican, Puer	Specify Yes or No rto Rican, etc.)	14.	Race - America Black, White,	
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id Hygiene. Id other than "neturel", or items 23e or 28e-f show event, the Medical Examiner must be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1□Yes 2□No	Specify:		Sp	ecity:	rite
21215-0036	turei	ed t	15. Decedent's Educ	cation		dent's Usual Occup			16b. Kind	of Business/Inc	
212	nin 72 In "ne Medik	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)		kind of work done DO NOT use retire		orking			
21	filed with Hygiene ther the	Com	12th	NA		Home	MAKER			Home	
nd	should be filed withir ad Mental Hygiene. marked other than matic event, the Mi	Be	17. Father's Name (First, Middle, Last)					me (First, Middle		mame)	
Maryland	should be tand Mental Is marked o	P	ALTONSE LAN		105 14-16	- Address /Comp.		es KI		Ctata Zia	Codel
Mai	12 s h ar 7 ls trau		19a. Informant's Name/Relationship (Typ		430	ng Address (Street	wood MV		-		C00e/
e,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other treumatic ODEs.		JAMES HARRYM 20a. Method of Disposition	20b. F	lace of Dispo	sition (Name of		Date	20c. Locati	ion - City or To	wn, State
IOT.	ages ant of at: if it y or c		Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	emoval from State	o RE I AA	natory`or other pla	6/1	1/04	Ba	Itc. M)
Baltimore,	mit. F partme portar injur		21 Signature of Funeral Service License		22	2. Name and Addre	ss of Facility	STULLA	FUNERA	(Itome	CHTD.
ä	Departiment of the particular in the particular		Haul M. =	tills	7	2. Name and Addre	FORD RU	1. Bolts	.M 2	1234	
1	Physician /Medical Examiner	16	23a. Part. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate	Due to (or as a conseq	uence of):						Approximate Interval Between Onset and Death
	uted I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	200 10 (0. 45 4 00.1004	33.133 3.7.						
oʻ	ate be executed only sician and the burial-transit		that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):						
8760,	ate be nysicia he bu	dicai	d								
Box 6	ath certific titending p or use as	an/Me	in the past 12 months?	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	Ideath 3	Ectopic pregnanc Other (specify)	у		23d.	Date of delive	ry Day Year
P.0	that the de led by the a detached f	Physici	9 Unknown		ulting in the	adachijas asusa su	uan in Dant I	23a Did	obacco use	contribute to th	e cause of death?
	sign and be	ρ	Part II. Other significant conditions con	induting to death but not res	uiting in the u	nderlying cause gi		1 🗆			ably 4 Unknown
oce	aw Is t	ompleted						24a. Was		4b. Were autop	osy findings available inpletion of cause of
œ .	The ate h page	Com						perfo 1 ☐ Yes	rmed? 2 ₩ No	death? 1 ☐ Yes	2 No
/ita	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	acnital:		0#	205	ath (Check only			
of	this aldi	. To	1 Yes 2 No		ER/Outpatier 28b. Time of		4 Nursing r	dome 5 Resi		Other (Specify)
uo	ding After fune	tion	1 ☐ Hatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	Wo	rk? Yes 2 □ No	Log. Describe	now injury oc	2001100	
Division of Vital Records,	or Atten ifter deal Director in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str y)	eet, factory, office		28f. Location (City or To	Street and No wn, State)	u <i>mber or Rural</i>	Route Number,
	e Hospital 24 hours a e Funeral I letely filled	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my knoter: On the basis of examina and manner stated.	wledge, death	h occurred at the ti vestigation, in my o	me, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and date and pla	d manner as sta ce, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	, m	D.	29c. Licens	se number		29d. Date si	gned (Month, L	Day, Year)
) IV	17(1	· ·	0	145391		June	. 9th	, 2004
	5		30. Name and address of person who comy of MAN (M.D.)				od # 2	200, B	el Air	, MD.	21014
	Sta		31. Date filed (Month, Day, Year)	32. Registrarts Signa	iture .	p					

			1 - For AMEND ITEM 1 Registrar	State of N	larylar G8	nd / Dep 32,067	rtificat	t of H DHB, e of L	ealth a D <i>eath</i>	and M	lental Hy	/giene Reg. No	∍2 Ō •.	04	18480
П			1. Decedent's Name (First, Middle, Las								2. Date of D			Yeer	3. Time of Death
	Physici /Medio		Preston Leroy	Holmes							June 8		004	1 991	9:29P. ^M
7	Examir		4a. Fecility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of	of Death		40	. County	of Death	
			Howard County Ger		pital	-		lumbi					Howa	ırd	
	Funeral		5. Social Security Number 6. S	9x 7. A IXM 2 ☐ F	ige (In yrs. 59	last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, D	ay, Yeer,)	Cour	
	Director		219-40-2142 Usuel Residence of Decedent	-		113.					Jan.14	, 194.	5	Mary	land
	and		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					_			10d. Inside City Limits
	Mary -f sh	ō	MD Howard			Jessup									1 ☐ Yes 2 H No
	28a	rec	10e. Street and Number		1	леззар	10f. Zij	Code				10g. Ci	tizen of V	Vhat Cour	ntry?
	3a or	Funeral Director	8854 Willowwood W	av				207	94			1	USA		
	death ma 2	ner	11. Marital Status	12. Was Deceden Armed Forces	t Eyer in U	I.S. t3.	Was Dece	dent of Hi	spanic Ori	gin? (Spe	ecify Yes or N Rican, etc.)	0-		e - Americk, White,	can Indian,
9	or ite	F	-1 Never Married XX Married	1 Yes 2 If Yes, Give				. /	Specify:	1, 1 00110	riioari, etc./		Specify		erc.
21215-0036	ours Fail,	d by	3 Widowed 4 Divorced	Year or Dates	:			2.01.10	Open,y.					Whi	
က်	72 h "natu	Completed	15. Decedent's Ed (Specify only highest gra			16a. Dece (Give	kind of wo	rk done d	luring most	t of work	ing	16b. K	and of Bu	ısiness/ln	dustry
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7	Hygie Hygie ther t		12 17. Father's Name (First, Middle, Last)	Ø		FILE	Fig	nter	18. Mothe	r's Name	First, Middle	-		d Cou	iiity
and	ontal l	Be C	Preston Robert Ho	1mes							Edna So			-,	
Maryland	should nd Me mark matic	2	19a. Informant's Name/Relationship (19b. Mailin	ng Address	s (Street a			il Route Numb			State, Zip	Code)
Z S	th ar th ar 27 is r trau		Mary Holmes / Wif	e		8854	Will	owwo	od Wa	v .	Jessup	Ma	arv1:	and 2	20794
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "netural; or items 23e or 28e-f show enty injury or other traumatic event, I'm Madical Examinar must be notified at ADEC.		20a. Method of Disposition			Place of Dispo cemetery, crei	sition (Na	me of			Date				own, State
OE.	Page ent o nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify		8	lt/Wash	-			-12-0)4	T.aı	ure1	Mar	vland
<u></u>	mit. J		21. Signature of Eugeral Service Licen		Da	22	. Name a	nd Addres	s of Facilit	y Fle	ck Fun				
Ö	Depariment Department on in poor		Dephone.	201_n	101=	50 7	601 8	Sandy	Spri	ing F	Road, L	aure	1, M	lary1	and 20707
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	one cause on each	line.		er the mod	de of dying	g, such as	cardiac o	or respiratory a	arrest,			Approximate Interval Between Onset and Death
ř.	Physician /Medical		disease or condition resulting in death)	a. Brain Due to (or a		rrhage									1 Day
30	Examiner			Hyport											Years
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Tryper to											rears
	cuted	III	that initiated events	c. Diabet	es									_1	Years
Ó	e exe	EX	resulting in death) Last	Due to (or a	s a conseq	(uence of):									
8760,	ficate be executed g physician and is the burial-transit	Ical		d											
9	Attending Physicien: The law requires that the death certificate be executed rideath. rideath. ector: After this certificate has been signed by the attending physician and y the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE:												
Вох	that the death certific ed by the attending p detached for use as i	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Feta	aldeath 3□	Ectopic p						23d. Date Mor	e of delive oth	Pry Day Year
0	the a	/slc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant 9☐Unknown	at time of c	leath 5L	Other (s	oecify)		-					
<u>α</u>	hat the od by detac		Part II. Other significant conditions of	ontributing to death	but not res	sulting in the u	nderlyina d	ause give	ın in Part I.		23e. Did	tobacco	use contr	ibute to th	ne cause of death?
Records,	signed to be det	d by	•	•		,	, ,				10	Yes 2	X□ No	3 Prob	ably 4 Unknown
Ö	w requir been si should	ete					-		-		24a. Was	20	24h V	Vere auto	psy findings available
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a	icien: Th certificate rector, pag	င္ပ	25. Was case referred to medical						OC Disease	of Dooth	1 Yes	2 X No	1	☐Yes	21XN0
Vital	ysicien: The is certificate hi director, page	o Be	examiner? 1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \)	Hospital: 1 ☐ Inpat	ient 213	ER/Outpatier	t 3 D	Othe	AC"		Te 5 Resi		s □Oth₄	er (Snecih	()
Division of	ig Phys ter this neral di	\vdash	27. Manner of Death	28a. Date of In	jury	28b. Time of		28c. Injury Work			28d. Describe				,
ion	Attending or death.	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	ay rear	Injury	М		res 2 🗆 1	No					
Vis	Atte	ertification:	3 ☐ Suicide 6 ☐ Could not be determined	289. Place of fi	njury - At h		eet, factor	y, office		1	28f. Location (City or To			er or Rura	l Route Number,
Ö	tel or	Cert		Jan. 19, 1	,.,.,.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						,				
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edlcal	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysicien: To the bes niner: On the basis and manners	of examina	owledge, death ation and/or in	occurred vestigation	at the tim , in my op	e, date and inion, deat	d place, a th occurr	and due to the ed at the time,	cause(s) date and) and mar d place, a	nner as st and due to	ated. the cause(s)
	o the ithin (o the smple	Med	29b. Signature and title of certifier	who manners		1	290	c. License	number		I	29d. Da	te signed	(Month,	Day, Year)
•	⊬≯≓ŏ		Roumer	L & 1	5	f-V	70	D363	371				-	10,	
			30. Name and address of person who	completed cause of	death (Iten	n 23a) (Type	Print)								
	J		Raymond E. Banfer			Cedar		e Co	lumbi	a, M	ld 2104	4			
174	Sta	te	31. Date filed (Month, Oay, Year)		trar's Signa		als			-					
	Registr	ar	JUN 1 4 2004	Jan 100	1	M	- was								

State of Maryland / Department of Health and Mental Hygiene ?

AMEND ITEM #8 PER FH G832 6/25/04 July dertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** June 10, 2004 Mary 11:00 AM Κ. Kennedy /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Unit 1308 Baltimore Baltimore 8808 Walther Blvd. 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1930 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex **Funeral** Months Days 1□M 20XF Hours Yrs 73 Director 069-24-3252 Usual Residence of Decedent Peges 1 end 2 should be tiled within 72 hours efter death with the Maryland nent of Health end Mental Hygiene. Interest of them 27 is marked other then "neturel; or items 23e or 28e-1 show ary or other traumetic event, the Medical Examinal mast be notified at 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director Baltimore Maryland Baltimore 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code U.S.A. Unit 1308 21234 8808 Walther Blvd. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ X lo Specify: Baltimore, Maryland 21215-0020 Specify <u>≯</u> 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Department Store Phone Operator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Loretta Μ. Loftus J. Spencer William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 614 Budleigh Circle 21093 Daughter Timonium, Maryland Anne K. Kennedy 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 20c. Location - City or Town, State Dulaney Yalley Memorial Gardens Department of Important: If it eny injury or o once. 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-15-2004 Timonium Maryland 21. Sign tone of Part rai Service Licensee 22. Name and Address of Fecility Ruck Towson Funeral Home, Inc. 21204 1050 York Road Towson, Maryland tagan 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical inferction Examiner Due to (or es a consequence of) the roscle rosi buriel-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, ettending physician for use es the burie Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown abdominal signed to d be dete Ď 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Be Completed Duep venous thrombosis ete has l 1 ☐ Yes 2 ☑No 1 ☐ Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 ☑ No this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation efter deeth. 2 Accident Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours e To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) D58646 June 10, 2004 an morico 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8800 Walther Blvd. Baltimore, Maryland 21234 Anne Monias, M.D. 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar JUN 1 **4** 2004

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Mary		artment of He	eath	Reg.	2009	18482
	Physici	an	Decedent's Name (First, Middle, Last)						Day Year	3. Time of Death
j.	/Medic	al	4a. Facility Name (If not institution, give	Thein Khin street and number)		4b. City, Town, or L		une 11,	2004 4c. County of Death	9:50 P.™
	Examin	eı	1610 Barthel Road	,		Lutherv	ille		Baltimore	е
	Funeral		5. Social Security Number 6. Sec	IM XTE	yrs. last birthday)	If Under 1 Year Months Days	Hours Min.	. Date of Birth (Month, Day, Ye	9. Birthp	place (State or Foreign ntry)
	Director		219-82-7964 Usual Residence of Decedent		88 Yrs.		S	ept. 15,	1915 Bu	rma
	yland		10a. State 10b. County		c. City, Town or Lo				1	10d. Inside City Limits
	e Mar	Director	Maryland Baltimore	2	Lutherv					1 Yes 2 XNo
	with th		10e. Street and Number			10f. Zip Code		_	Citizen of What Cour	
	ns 234	Funeral	1610 Barthel Road	1 12. Was Decedent Ever	in U.S. 13.	21093 Was Decedent of His If Yes, specify Cuban	panic Origin? (Speci		ited State	
98	J within 72 hours after death with the Maryland jiene rthen "natural", or Itams 23a or 28a-f show the Medical Examination notified at	y Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🏋 No If Yes, Give			, Mexican, Puerto Ri Specify:	can, etc.)	Black, White,	etc.
000	hours tural',	ed by	3 X Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates:		dent's Usual Occupati	ian	166	As Kind of Business/In	sian dustry
-15	nin 72 n "nat	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work done du DO NOT use retired)		100	, Kind of Dusinessin	dostry
212	od within giene. ar than "	Com	12	-0-		Homemaker			Own Home	2
Maryland 21215-0036	ld be filed ental Hygie kad othar Ic evant, t	Be	17. Father's Name (First, Middle, Last) U Kyan			1	18. Mother's Name (i Daw Hni		den Sumame)	
ryla		은	19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Maili	ng Address (Street an			tv or Town, State, Zin	Code)
	olth a		Dr. Mehm T. Thaung		L	Barthel Ro				,
Je,			20a. Method of Disposition	2	0b. Place of Dispo		Dat		Location - City or To	own, State
Ë	Pages ment of I ant: If its ury or o		1 ☐ Burial 2 🖺 Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)		Bayview (Crematory	June 12,	2004	Baltimore,	Maryland
Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Euneral Soyrice Licenso	Bı		Chisholm F 200 E. Pad			_	Valley, P.A 1093
Г			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the ne cause on each line.	death. Do not en			espiratory arrest,		Approximate Interval Between Onset and Death
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ř	acuted Ind transii	Examine	Cause (Disease or injury that initiated events resulting in death) Last	DISTA						
8760,	be executed sician and burial-transit	al E)	Totaling in docum, cast	Due to (or as a co	nsequence oi):					
687	ficate I g physi	edical		J						
Вох	death certificate be executed e attending physician and ad for use as the burial-transit	M/UE	230. was decedent pregnant	3c. If yes, outcome of pour 1 Live birth 2 □		Dectopic pregnancy			23d. Date of delive	
O. B	the att	hysician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time 9☐ Unknown		Other (specify)			Month	Day Year
0	law requires that the de as been signed by the a 2 should be detached	Q.	Part II. Other significant conditions cor	ntributing to death but no	t resulting in the u	nderlying cause given	in Part I.	23e. Did tobaco	co use contribute to the	ne cause of death?
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eco	law requas been 2 should	ompleted						24a. Was an autopsy	prior to cor	psy findings available mpletion of cause of
E E	: The la	Con						performed 1 ☐ Yes 2 🔀		2 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:	аП. Г. Г. Г. Г. Г. Г. Г. Г. Г. Г. Г. Г. Г.	Othor	26. Place of Death (0			
of		To To	1 ☐ Yes 2 🛣 No	1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatier	IL 3 DOA	4 Nursing nome	5 M Residence d. Describe how in	6 ☐ Other (Specification)	y)
ion	들는동호	atlor	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ar) Injury		es 2 🗆 No			
Division	after death after death Diractor: I in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, sti pecify)	reet, factory, office	28f	Location (Street City or Town, St	and Number or Rura ate)	l Route Number,
	Hospital of the same of the sa		29a. Certifier 1 Certifying Phys	sician: To the best of m	/ knowledge, deat	h occurred at the time	date and place, and	due to the cause	a(s) and manner as si	hatel
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	ledical	(Check only 2 Medical Examilations)	sician: To the best of maner: On the basis of exa and manner stated.	mination and/or in	vestigation, in my opir	nion, death occurred	at the time, date	and place, and due to	the cause(s)
	To the within 2 To the complete	Ž	29b. Signature and title of certifier			29c. License r		29d.	Date signed (Month,	
				me, mo			7753		6-12-	04.
	6		30. Name and address of person who co	SENA, M.D.	710	CHURCH	ST. BA	LTIMOS	LE, MD	21225 .
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 4 2004	2. Registrar's	Signature Ape	de				

		Plea 1 - State Registrar		aryland / Dep	delible Ink. Ensure A artment of Health and artificate of Death	Mental Hygi		18483
Physicia /Medic			VILLIAM		KURZ	2. Date of Death Month	Day Yeer 200	
Examin Funeral	er	4a. Facility Name (If not institution Since Flos 5. Social Security Number	pital of Bo	Utimore go (In yrs. last birthday	Ab. City, Town, or Location of Dea Boultimane Color of Under 1 Year If Under 24 Hrs Months Days Hours Min	8. Date of Birth	4c. County of Deal	N/A thplace (State or Foreign
Director		319-26-8346 Usual Residence of Decedent 10a. State 10b. Count	1	92 Yrs.		MAY 1,	1912	GERMANY 10d. Inside City Limits
with the Man is or 28a-f sh	Director	MD 10e. Street and Number 7209 CREST WA	N/A N/ A APT #A_		TIMORE 10f. Zip Code 21208	10	g. Citizen of What Co	1 1 Yes 2 □ No buntry? U.S.A.
within 72 hours after death with the Maryland ene. Than "natural", or tems 23a or 28a-f show tra Madical Examirar must be notitied at	by Funeral	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	12. Was Decedent Armed Forces 1 □ Yes 2 X	Ever in U.S. 13.	Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☒ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	encan Indian,
s 1 and 2 should be filed within 72 hc if Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, tra Magical	Completed		ent's Education est grade completed) College (1-4or	(Give	edent's Usual Occupation a kind of work done during most of wo DO NOT use retired) & PRODUCTION	orking	6b. Kind of Business	
al Hygie d other	Be C	17. Father's Name (First, Middle	, Last)		18. Mother's Na	me (First, Middle, Ma		
should be nd Mental marked c	5	HERSH	sahin (Time China)	KUR				JNKNOWN)
Health and tem 27 is nother traun	1 1	19a. Informant's Name/Relation ANITA PREIS / 20a. Method of Disposition		3501 20b. Place of Disp	ing Address (Street and Number or R SEVEN MILE LANE osition (Name of	- BALTIMOI		208
0 0		1 X Burial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other ()	HAVAS CHESED 6/1	1/2004	RANDALLSTO	WN, MD
permit Pag Department Important: I any injury o		21. Signature of Funeral Service	a Licepsee With		2. Name and Address of Facility S			
Physician /Medical Examiner	ler	23a. Part1. Enter the disease, shock, or heart failure. List immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. if any, leading to immediate cause. Enter Underlying	a. Sept	ine.	nter the mode of dying, such as cardia	c or respiratory arres	it,	Approximate Interval Between Onset and Death A DW 10 days
tificate be executed og physician and as the burial-transit	ledical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	s a consequence of):				
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the logical page.	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	ivery Day Year
w requires that the de been signed by the a should be detached I	by	Part II. Other significant condi	tions contributing to death t	but not resulting in the	underlying cause given in Part I.		cco use contribute to	
sician: The law r certificate has be irector, page 2 sh	Completed	Coronary	artery	disease		24a. Was an autopsy performe 1 Yes 2	prior to death?	atopsy findings available completion of cause of
Physician: r this certific ral director,	o Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ient 2 ER/Outpatie	Other	ath (Check only one) Home 5 - Residen	ce 6 ☐Other (Spec	c(fy)
inding Phy ath. r: After this	ation: T	E L MODIGOTIC	28a. Date of Injuring (Month, Date of Injuring (Month, Date of Injuring (Month, Date of Injuring Injur	ury 28b. Time o		28d. Describe how		,,
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Certification:	4 Homicige	mined 200. Place of in building, e	njury - At home, farm, si tc. <i>(Specify)</i>		City or Town,		
e Hosp 124 hou e Funei letely fil	edical			of examination and/or in tated.	th occurred at the time, date and plac nvestigation, in my opinion, death occ	urred at the time, date	e and place, and due	to the cause(s)
To the withir To the Comp	Me	29b. Signature and title of certif	a MD		29c. License number RES-000 Print) Hospital	290	1. Date signed (Mont)	1, Day, Year)
/		30. Name and address of person Han4 Bay		death (Item 23a) (Type	Print) Hospital	of B	altimon	e
Sta Registi		31. Date filed (Month, Day, Yea	ur) 32. Regist	trar's Signature	books			

Fatient Known as Kurr William

Baltimore, Maryland 21215-0036

 $\stackrel{\textstyle \swarrow}{\sim}$ Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death **Physician** ²2004 Year JUNE 9, DORA KORNBLIT 9:10 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 7 PICASSO COURT PIKESVILLE BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 85 yrs. 8. Date of Birth (Month, Day, Year) 8/13/1918 Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 □ M 2 😿 F 213-60-7446 POLAND **Director** Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location an "natural", or Itams 23a or 28a-f show Medical Examinar must be nutified at 1 ☐ Yes 2 No BALTIMORE BALTIMORE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21209 2708 SUMMERSON ROAD permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Itams 23a any injury or other traumatic event, Ih. Medical Examiner must once. U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No WHITE Specify: þ 3 X Widowed 4 ☐ Divorced leted 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Elementary/Secondary (0-12 Compl College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SARA WIDL WARTMAN (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3111 NORTHBROOK ROAD - PIKESVILLE, MD 21208 CHAIM KORNBLIT / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) TAMID 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State LUBAWITZ NUSACH ARI NÉR 6/11/2004 ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the rise to a or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head alluminations on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) cestate **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). attending physician and for use as the burial-transit to the Hospital or Attending Phyalcian: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a Yes 2 No 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 3 Probably 4 □Unknown 1 | Yes 2 | 1 No Completed bluods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2□ No 2 🐷 1 Yes 1 Yes 25. Was case referred to medical examiner? DAUGHTER'S Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 XOther (Specify) 1 ☐ Yes 2 ☐ ¥6 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Diractor: After the in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours 29a. Certifier 1 🖵 certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (1055700ch alno 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 4 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			_	State of Mary							iene 200	1 10105
		-	For State Registrar			Cer	tificate	of Death		Re	g. No.	4 18485
	Physicia		1. Decedent's Name (First, Middle, Last)			-				Date of Deat Month	Day Year	3. Time of Death
	Physicia /Medic	_		sen						ine 4	2004 4c. County of Dee	5:30 P M
1	Examin	er	4a. Fecility Name (If not institution, give st					own, or Location of D)ea(n			ın
	Funeral		4207 Valley View 5. Social Security Number 6. Sex	Avenue 7. Age (//	n yrs. la	ast birthday)	If Under 1		Hrs. 8.	Date of Birth (Month, Day,	Vesci 9. Bit	thplace (State or Foreign
	Director		219-10-0193	M 2□F 83		Yrs.	Months [Days Hours I	Min. Se	ept. 1		aryland
	DG * 122		Usual Residence of Decedent 10a. State 10b. County	10	0c. City	, Town or Lo	cation		-			10d. Inside City Limits
	/anyle	ŏ				Balt	imoro					1 XYes 2 □ No
	28a-	Director	Maryland N/A 10e. Street and Number			Dait.	10f. Zip C	ode		10	0g. Citizen of What C	ountry?
	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. All Hygiene. do ther than "natural", or Items 23s or 28s-f show event, it a Medical Examinar must be notified at	a D	4207 Valley View	Ave				21206			U.S.A	.4
	ens :	Funeral		2. Was Decedent Eve Armed Forces?	er in U.S	S. 13. \	Was Deceder f Yes, specify	nt of Hispanic Origin y Cuban, Mexican, P	? (Specify Puerto Rica	Yes or No- an, etc.)	14. Race - Am Black, Wh	
9	s afte	by Ft	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊟ Yes 2X No If Yes, Give Year or Dates:			¹□Yes 2□	XNo Specify:			Specify:	hite
-020 -020	filed within 72 hours after Hygiene. ither than "natural", or Ite ent, Ite Medical Exam re		15. Decedent's Educ			16a. Deced	ient's Usual (Occupation			16b. Kind of Business	
7	nin 72 In "na Medic	piet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		(Give life. l	kind of work DO NOT use	done during most of retired)	f working			
7	e filed within al Hygiene. I other than vent, it a Ma	Completed	10Th. Grade			Te	lephon				K&E Inc.	
Ě	d oth	Be	17. Father's Name (First, Middle, Last)								faiden Sumame)	
	2 should be and Mental ie marked raumatic ev	၉	George F. Br	OWN		19b Mailir	na Address (S			e oute Number.	Conway City or Town, State,	Zip Code)
Ž	D = 5 = 1		Sharon Mette / Da								Worth FL.	
ā,	permit. Pages 1 and. Department of Health important: If item 27 eny injury or other tr		20a. Method of Disposition		20b. PI	lace of Dispo	sition (Name	of	Date		20c. Location - City o	
Ê	Page nent o int: If iry or		1 Buriel 2 □ Cremation 3 □ Re Contains 5 □ Other (Specify)	moval from State					6/7/2	2004	Baltimor	e MD
baitimore,	permit. Departr imports eny inju		21. Signature of Funeral Service License		>	22	Name and Mill	Address of Facility	Fune	eral He	ome. Inc.	
Ц	20539		23a. Pert1. Enter the disease or emplic		- do o th	Do not ont	6415	er-Dippel Belair R	load	Balti	nore MD	21206 Approximate
			shock, or heart failure. List only one	ations that caused the cause on each line.	e deali	1		or cyrrig, such as ca	I GIAC OI 16	spiratory arre	331,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a c	odsed		mA					190.
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289	leath certificate I attending physical I for use as the t		_ d.									
Rox	death certifical e attending phi d for use as th	Physician/Med	23b. was decedent pregnant	3c. If yes, outcome of 1 ☐ Live birth 2 {			Ectopic pred	onancy			23d. Date of de	
	0 0 2	sicia	in the past 12 months? 1 Yes 2 No	4☐Pregnant at tirr 9☐ Unknown			Other (spec				Month	Day Year
J.	nat the d by ti letach	Phy	9 ☐ Unknown Part II. Other significant conditions con		not resi	ulting in the u	nderlying cau	ise given in Part I		23e. Did tok	pacco use contribute	o the cause of death?
g D	The law requires that the de ite has been signed by the a bage 2 should be detached f	d by	Part II. Other significant conditions con	industry to doubt but t	1001030	annig iii tilo d	riddryllig dae	good given in a circu		1 □ Ye	1	robably 4 Unknown
Vital Records,	v req been shou	Completed								24a. Was a	n 24b. Were a	utopsy findings available
Ä	Physician: The lav this certificate has al director, page 2	omp							_	autops perford	ned? death?	completion of cause of
ta		a	25. Was case referred to medical					26. Place of	f Death (C	heck only on	-	
>	hysici his ce I direc	To B	examiner?	ospital: 1 Inpatient	2 🗆	ER/Outpatier				-	ence 6 Other (Sp	ecify)
n c	ing P	ion:	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Y	(ear)	28b. Time o Injury	M 280	c. Injury at Work? 1 ☐ Yes 2 ☐ No		. Describe ho	ow injury occurred	
Division of	death ctor:	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury	r - At ho	ome, farm, str					reet and Number or F	lural Route Number,
<u> </u>	after after Dire	Certification:	4 Homicide	building, etc. ((Specif)	y)	ocani i			City or Towr	, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C		ician: To the best of refer: On the basis of earth manner state	xamina							
	To the within 2 To the comple	Mec	29b. Signature and title of certifier				29c.	License number		2	9d. Date signed (Mor	th, Day, Year)
	,1		1 /209	auris			T	2067	3		6/4/00	/
	7		30. Name and address of person who co	mpleted cause of dea	th (Item	n 23a) (Type.	Print)	ND ZIZ	26		1117	
100	1		31. Date filed (Month, Day, Year)	32. Registrar	72 s Signa	WY 1	419	10000	10			
	Sta Regist		JUN 1 4 2004	Seran Seran	Signa	de	racks	/				

	1 - For State Registrar	State of Maryla			alth and Me	ental Hygie	ene	04 1848
Physician /Medical Examiner	Decedent's Name (First, Middle, Last, Kathryn 4a. Facility Name (If not institution, give)	Marie L	ogue 4b.	City, Town, or Lo		2. Date of Death Month June 6,	Day Y 2004 4c. County of	3. Time of Death 9:56 A
Funeral Director	212-30-6410	7. Age (In yrs	s. last birthday) If U		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, Y ept.10,	Carro (ear) 9 1947	. Birthplace (State or Foreig Country) Maryland
with the Maryland a or 28a-1 show the notified at	Usual Residence of Decedent 10a. State 10b. County		Westmins			100	. Citizen of Wha	10d. Inside City Limit 1 □ Yes 2 💢 N
036 us after death ut, or items 23 conjuer mus by Funeral	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	If Yes	es 2∭X No S	nic Origin? (Spec Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	U.S 14. Race- Black, Specify:	.A. American Indian, White, etc. White
ind 21215-0036 be filed within 72 hours att lat Hygiene. d other then "natural", or event, the Medical Exemi Be Completed by F	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	cation e completed) College (1-4or 5+) 4	Commerci	al Prope	ng most of working	ger	b. Kind of Busin Real E iden Sumame)	,
Maryland nd 2 should be file and 2 should be file alth and Mental Hy 127 is marked oth re traumatic event To Be (19a. Informant's Name/Relationship (Ty	Logue, Jr po. Print) Attorney	19b. Mailing Add		Anna Number or Rural		ity or Town, Sta	
Baltimore, permit. Pages 1 ar Department of Hea Important: If Item any injury or othe once.	20a. Method of Disposition 1X Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Fuhern Service License	emoval from State	Place of Disposition cometery, crematory rkwood Cer 22. Nam	(Name of or other place) netery	June Facility Ruc	10,2004	Baltim Funera	y or Town, State ore Maryla 1 Home, Inc.
3760, ate be executed be executed wysician and he burial-transit cal Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only brown the complete of the complete	Due to (or as a conse	quence of):					Approximate Interval Between Onsel and Death
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on of ding Phys	1 Yes 2 No H 27. Manney of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	ospital: 1 Mnpatient 2 28a. Date of Injury (Month, Day Year) 28e. Place of Injury · Al h building, etc. (Special Control of the Control of t	28b. Time of Injury M	DOA Other: 4 28c. Injury al Work? 1 Yes	Nursing Home 28	5 ☐ Residence	njury occurred	Specify) r Rural Route Number,
Hospite 24 hours Funeral stely filled	one)	ician: To the best of my kn er: On the basis of examin- and manner stated.	owledge, death occu ation and/or investiga	rred at the time, d tion, in my opinio	ate and place, and n, death occurred	d due to the cause at the time, date	e(s) and manne and place, and	r as stated. due to the cause(s)
To the within To the comple	29b. Signed and title of certifier 30. Name and address of person who co	mpleted cause of death (Itel	m 23a) (Tuna Print	29c. License nur	mber - Deco	29d.	Date signed (M	onth, Day, Year)
State Registrar	CHITRACITEDY N 31. Date filed (Month, Day, Year) IIIN 1 4 2007	32. Registrar's Sign		paole 1	ld W	ESTAMIN'S	S I E I C	m) 01157

DHMH 17 Rev 1/2001

Lobue

			1 - For State Registrar		State of	Marylar		artment rtificate				lental H	ygiene Reg. No	200		181.87
			Decedent's Name (Fire	rst, Middle, L	ast)							2. Date of D		, 0		3. Time of Death
	Physic - /Medi		Emma Marga	aret	Moeller							June	Da 1 (ear 04	3:10PM
	Exami		4a. Facility Name (If not					4b. City, T	own, or	Location of	of Death	barre		. County of		3:10
			St. Martin	n's H	ome			C	ato	nsvi	ille			Balt	i-mc	ro
	Funeral		5. Social Security Number	er 6.	Sex	7. Age (In yrs.	last birthday)	If Under	Year	If Under	24 Hrs.	8. Date of B	irth			ace (State or Foreign try)
ш	Director		213-34-5944		1□M 2∏F	87	Yrs.	Months	Days	Hours	Min.	Sept 4			ary]	
	and w		Usual Residence of Dec	edent c. County		100 Cit	y, Town or Lo	antina								
	show	5		altimo	ro	100. 01	Catons								10	Od. Inside City Limits
	the A	Director	10e, Street and Number	arcino	16		Catons									1 ☐ Yes 2X No
	with e or		601 Maiden	Choico	Lano			10f. Zip (izen of Wha		•
	be filed within 72 hours after death with the Maryland talt Hygiene. ad other then "naturel", or flems 23e or 28e-f show event, the Marficel Franch event, the Marficel Franch event.	Funeral	11. Marital Status	CIOICE	12. Was Dece	tent Ever in II	C 12.1		228		-1-0 (0-			ted St		
	ter d	Ë	1 Never Married	2□ Married	Armed For	ces?	.5. 13.	Yes, specif	but of His by Cubar	spanic Orig n, Mexican	gin? (Sp. , Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Black, 1	America White, e	
38	urs al		3 XWidowed 4 □		If Yes, Give	•		∏Yes 2	X No	Specify:				Specify:		White
21215-0036	2 hot	Completed by	15. I	Decedent's E	ducation		16a. Deced	lent's Usual	Occupa	tion			16b Ki	ind of Busin	ass/Ind	ueto
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<u> a</u>	should be and Mental s marked o	70 6	Arthur P. M	urphy						Emma	Nor	đt				
Maryland			19a. Informant's Name/F									il Route Numb				
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Baltimore,	es 1 av of Hea fitem rothe		20a. Method of Disposition 1		Bomoval from C		lace of Dispo-	atory or oth	er place) 1	C	ate	20c. Lo	cation - City	y or Tow	m, State
Ē	Pages ment of ant: If it ury or o		`4 □Donation 5 □			Mi	llersyi monite	lle	tors	,	ממנו	12,2004	, Mi	llers	vil.	le, PA
at	permit. Pages 'Department of H Important: If ite any injury or ot once.		21. Signature of Funeral	Service Lice	nsee	1,101	22	Name and	Address	s of Facility		bard Fi		1 Hom	_	
ш	207	. 112	unn	. y.	xulk	<u></u>	41	07 Wi	lker	s Ave	enue	. Balti	more			nd 21229
			23a. Part1. Enter the dis shock, or heart failu	sease, of con ure. List only	polications that ca	used the deatl	n. Do not ente	er the mode	of dying	, such as o	cardiac c	r respiratory a	rrest,		-	Approximate Interval Between
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	/Medical		resulting in death)	-	Due to (o	r as a conseq	uence of):								1	o alays t
	Examiner		Sequentially list condition	ns	b. —											
	p #	Examiner	Sequentially list condition if any, leading to immedi- cause. Enter Underlying	ate 2	Due to (o	r as a consequ	uence of);									
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9		Me	IF FEMALE:		00 1/											
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ds,	signed be det	d by	ESSEN			PERT			se givei	i ii raiti.						cause of death?
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Vital Record	e law has ye 2 s	Completed	ALZ+(E	IME	R'S D	FME)	VTIA					24a. Was autor	osy	prior	to comp	y findings available pletion of cause of
		S						_				1 ☐ Yes	rmed? 2 No	death	1? /es 2	□No
Z.	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to examiner?	medical	Hoopital						of Death	(Check only c	one)			
of	Phys this al dii	L	1 ☐ Yes 2 No 27. Manner of Death		Hospital: 1 Inf		ER/Outpatient	3□ DOA	Other	4 Nurs		ne 5 ☐ Resid			pecify)	
n	ding I	o	1 Natural 5	Pending		Day Year)	28b. Time of Injury		. Injury a Work?			8d. Describe I	now injury	occurred		
Si	ttend death stor: the	icat	2 Accident 3 Suicide 6	investigation Could not b	θ	the Ann		М		es 2 ∐ N	-					
Division	of or Attend after death Director: ,	Certification:	4 Homicide	determined	building	l Injury - At ho , etc. <i>(Specify</i>	me, farm, stre	et, factory, c	office		2	8f. Location (5 City or Tox	Street and vn, State)	Number or	Rural F	Route Number,
	pitel		29a. Certifier	Cartifying Dh	Weiging: To the b		dada day									
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	(Check only 2 N	Madical Exar	nysician: To the b niner: On the bas and manne	is or examinat	vieuge, death ion and/or inve	estigation, in	my opir	, date and nion, death	place, a occurre	nd due to the d at the time,	cause(s) a date and p	and manner place, and c	as state	ed. ie cause(s)
	omple	Me	29b. Signature and title of		^	Juneau.			icense r					signed (Mo		
13			· Kan	ral.	leray	DALD		D	183	162				-11-		
			30. Name and address of	person who	completed cause	of death (Item	23a) (Type P									
	'	. 1	KOMALK.I	ANG	M.D. 3	YS5, 1	wilke	as A	rue	Sui	te 3	08.	Bal	to.	Md	121229.
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DHMH 17 Rev 1/2001

ORIGINAL

			1- State of Maryland State of Maryland		artment of H tificate of L				04	18488
	Physici		Decedent's Name (First, Middle, Last) Madge Lois				2. Date of Dea Month	th Day	Year 201214	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Cent		4b. City, Town, or			4c. County of	of Death	imore
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. las. 226−38−5393 1	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Birth Win. (Month, Day June 4	, Year)	Count	ace (State or Foreign ry) inia
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "netural", or items 23a or 28e-f show other treumetic event. Ite Medical Exercited must be invitible 1 at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, 1 Maryland Baltimore 10e. Street and Number 8211 Watersedge Road 11. Marital Status 12. Was Decedent Ever in U.S.		10f. Zip Code	21222	ndalk ? (Specify Yes or No-	Og. Citizen of W United 14. Race	/hat Count Stat	es an Indian,
21215-0036	within 72 hours after of and and and and and and and and and and	Completed by Fur	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Deced (Give life. L	Yes, specify Cubal □ Yes 2录No lent's Usual Occupa kind of work done a DO NOT use retired ece Work	Specify: ation furing most of		Specify:	siness/Ind	hite ustry
Maryland 2	uld be filed flental Hygis rked other tic event.	To Be Co	12 Years 17. Father's Name (First, Middle, Last) Charles Henry Whitt	PI	ece works		Name (First, Middle,		e)	ons
	ss 1 and 2 should be of Health and Mental item 27 is marked r other treumetic ev		Mrs. Patsy A. Eavers/Daughter	2805	Artemus		aldwin, Ma	ryland	2101	3
altimore,	permit. Pages 1. Department of He Importent: If iten any injury or oth		1 □ Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 ☑ Other (Specify) Entombmt. Gdn	etery, crem 15. Of	sition (Name of natory or other place Faith Co	em. 6/		20c. Location - (m, State Maryland
Ball	permit Depart Import any in		21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease or complications that caused the death.	Du 7	922 Wise	Funeral Ave. I	l Home of i	ryland	212	• 2.2 Approximate
	Physician /Medical		shock, or heart failure List only one cause on each line.	STRU			ARY DISES			Interval Between Onset and Death
8760,	Examiner physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence).	es of):						
.O. Box 6	death certifi e attending od for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	ath 3	Ectopic pregnancy Other (specify)		2/16-2/16-2	23d. Date Mont		y Day Year
<u>α</u>	Pe igi	by	Part II. Other significant conditions contributing to death but not resultin	ng in the un	iderlying cause give	in in Part I.	23e. Did tot			cause of death?
I Records,	The ate h page	Completed	HYPERTENSION				24a. Was a autops perforr	y pr negl? de	ior to come	sy findings available pletion of cause of
ion of Vital	Attending Physicien: The death. ector: After this certificate by the funeral director, pag	To Be	F. A.	Outpatient b. Time of Injury	28c. Injury Work	4 Nursir	Death (Check only on ng Home 5 Reside 28d. Describe ho	ence 6 Other		
Division	i Sir de	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location (St City or Town	reet and Number n, State)	r or Rural i	Route Number,
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	dge, death and/or inv	estigation, in my op	inion, death o	occurred at the time, da	ate and place, ar	nd due to t	he cause(s)
)	To with	Σ	29b. Signature and title of certifier	~	29c. License		2:	9d. Date signed	(Month, Di	ıy, Year)
	7		30. Name and address of person who completed cause of death (Item 23	ER I		ADRIGO	I, MARYLAN	D 2120	4	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signatur	4	call					

			For State Registrar		State	of Maryla		epartment Certificate			Mental Hy	giene Reg. No. 🤈 🏻	101.	10100
	Physici /Medic		1. Decedent's Name Marga		Mary	Mart	tin				2. Date of De Month	Day	Year 2004	3. Time of Death
4	Examir		4a. Fecility Name (III	N SQL	LARE	Hospi	HAL	RO	50 D	cation of Death MALE		4c. County	of Death	de
	Funeral Director		5. Social Security No. 215-54-0796 Usual Residence of		Sex 1 □ M 2 □ F	7. Age (In y		rs. If Under 1		Under 24 Hrs. Hours Min.	8. Date of Bit October	18, 1949	9. Birthpl Mary	lace (State or Foreign Tand
	death with the Maryland ma 23a or 28a-f show	or	10a. State	10b. County Baltimor	·e	10c.	City, Town	or Location					10	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the last or 28a-	Director	10e. Street and Nun					10f. Zip (10g. Citizen of \	What Coun	try?
	death ma 23	Funeral	3417 Salt	uda Koad	12. Was Dec	edent Ever in	u.S.	13. Was Decede	.236 nt of Hispa	anic Origin? (Sp	pecify Yes or No	USA 14. Rac	e - Americ	an Indian,
036	n 72 hours after death with the Marylan "natural", or Itsma 23a or 28a-f show offeal Examiner must be notified at	þ	1 ☐ Never Marrie 3 ☐ Widowed	ed 2 Married 4 Divorced	Armed Fr 1 Yes If Yes, Gi Year or D	2 X]No ve		If Yes, specif		Mexican, Puerto Specify:	Rican, etc.)	Specify	ck, White, e /: Wh	ite
5-0		letec	(Speci	15. Decedent's E ify only highest gra	ducation ade completed)		16a. (Decedent's Usual Give kind of work life. DO NOT use	Occupation done during	n ng most of work	king	16b. Kind of B	usiness/Ind	lustry
250		Completed	Elementary/Secon			1-4or 5+)	_	cretary				Hedwin C		astics
Wand 21	ges 1 and 2 should be filed within to f Health and Mental Hygiene. If item 27 Is marked othar then or other treumatic evant, If a M	To Be	17. Father's Name (Joseph		DiPasqua	le				Angelin	a	Maiden Suman Ferra	ro	
, Mar	1 and 2 sh Health and tem 27 la m othar treum		19a. Informant's Na Martin Lack		Type, Print)			Mailing Address (100 Oakmont					State, Zip	Code)
Jath W	permit. Pages 1 and Department of Health Importent: If item 27 any Injury or othar tr once.			osition Cremation 3 5 5 Other (Special		State	cemetery	Disposition (Name , crematory or oth Memorial	er place)	6/16/	Date 04	20c. Location - Baltimo		
Balt	permit. Pag Department Importent: I any Injury o		21. Signature of Fu	peral Service Lice	° Willi.	am G. Da	au	22. Name and 5305 Har1		_	eonard J. more, MD	Ruck, In 21214	c. Fun	eral Home
	Physician		23a. Part 1. Enter the shock, or hear Immediate Cause (I disease or condition	Final		caused the de each line.	1	eurvs		uch as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death Z Hours
	/Medical Examiner		resulting in death)	ſ	-	(or as a cons			7 7 1					E 118ars
	uted d ansit	Examiner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or i that initiated events	nditions, mediate rhying injury	Due to	(or as a cons	equence of):						
Box 68760,	ate be executed physician and the burial-transit		resulting in death) L	ast	Due to	(or as a cons	equence of):						
89	entifica ing ph e as th	Med	IF FEMALE:	T										
0. Bg)	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transi	Physician/Medical	23b. Was decedent in the past 12 1 1 Yes 2 1 2 1 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2	months?		oirth 2 □ Fe nant at time o	etal death	3 ☐Ectopic preg 5 ☐ Other (spec				23d. Dat Mor	e of deliver nth (ry Day Year
ds, P.	uires that the signed by	by	Part II. Other signifi	icant conditions	contributing to d	eath but not r	esulting in t	he underlying cau	ise given in	Part I.		-	ibute to the	e cause of death?
Division of Vital Records	he law requir e has been s age 2 should	Completed										rmed? d	rior to com leath?	sy findings available
ita	Physician: The lavithic cortificate has al director, page 2	Be Co	25. Was case referr	ed to medical					26	. Place of Deat	1 ☐ Yes h (Check only o		☐ Yes 2	2 ⊠ No
<u>></u>	hysic this ce al direc	으	examiner? 1XYes 2 1				ER/Outp			4 ☐ Nursing Ho		dence 6 Othe)
on (ftei	tion:	27. Manner of Death 1 Natural 2 ☐ Accident	n 5 ☐ Pending investigation		of Injury th, Day Year)	28b. Tir Inj	ne of 280 ury M	Unjury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe I	now injury occurre	be	
Divisi	To the Hospitel or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 4 Homicide	6 Could not b	e 28e. Place	of Injury - Ating, etc. (Spe	home, farm	n, street, factory,			28f. Location (S City or Tox	Street and Number vn, State)	or Rural	Route Number,
	s Hospite 124 hours 16 Funeral	ledical C	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exar	niner: On the b	best of my k asis of exami ner stated.	nowledge, ination and/	death occurred at or investigation, in	the time, d	late and place, on, death occur	and due to the ored at the time,	cause(s) and mandate and place, a	nner as sta and due to t	ited. the cause(s)
	To th withir To th comp	Me	29b. Signature and	title of certifier	5) = =	1.	29c. I	icense nu	117		29d. Date signed		
	15		30. Name and addre		415	,	em 23a) (T	11211		1. +1.04		June Marylan		1004
	Sta		31. Date filed (Monti		32. F	egistrar's Sig	nature	0 17.11		WINER	NINIE 1	lary lan	0 2	1013
	Registr	ar	JU	N 1 4 200	14	eneral	_	spor	K					

			For Stete Registrar	State of M				of Health a	and M		giene 2	004	18490
	Physic		Decedent's Name (First, Middle, L.	ası) Myrtle	e R.	Mai	rtin			2. Date of Dea Month	th Day	Year	3. Time of Death 11:30PM
	/Medi Examir		4a. Facility Name (If not institution, gi		1	4	b. City, Tov	wn, or Location o		June 4	4c. Cou	inty of Death 1timor	
	Funeral Director				ge (In yrs. last birt 82		If Under 1 Y Months D		24 Hrs.	8. Date of Birth (Month, Day Dec. 25	Year)	9. Birth	place (State or Foreign
	Maryland a-f show iffied at	ctor	10a. State 10b. County	Ltimore	10c. City, Town	or Locat	tion			Dunc	lalk	1	10d. Inside City Limits 1 ☐ Yes 2 💆 No
	th with the 23a or 28 Ist be no	ai Director	10e. Street and Number 3228 Wallford Di	rive			10f. Zip Co		21222			of What Cour	•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or items 23a or 28a-1 show any injury or other traumette event, I're Modical Examinar must be notified at ORCE.	by Funerai	11. Marital Status 1 Never Married 2 Married 32 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		1	s Decedent es, specify Yes 202	of Hispanic Orig Cuban, Mexican No Specify:	gin? (Spec , Puerto F	cify Yes or No- lican, etc.)	E	Race - Americ Black, White, ecify: Wh	
21215-0036	within 72 ho ene. than "natur ne Medical	Completed	15. Decedent's 8 (Specify only highest g			(Give kin life. DO	t's Usual O d of work d NOT use n	one during most etired)	of workin	g		f Business/In	
Maryland 2	ould be filed Mental Hygi arkad othar atic evant, I	To Be Co	12 Years 17 Father's Name (First, Middle, Las Jesse Ruark	t)		1100	ABCW II	18. Mother		(First, Middle, I	Maiden Sun		
e, Mar	1 and 2 she Health and em 27 Is ma		19a. Informant's Name/Relationship Betty Jane Guest 20a. Method of Disposition			5814	Gar	reet and Number nbrill R	oad	Whitem	arsh,	Mary1	and 21162
Baltimore,	it. Pages intment of h intant: If ite njury or of		1 ⊠Seurial 2 □ Cremation 3 ('4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice	ify)	cemetery	v, cremate v ri do	ge Mer	n. Park		2004	Dors		ryland
Ba	Depril		23a. Bant 1. Enter the disease or cor shock, or heart failure. List only		the death Don	7	922 W	ddress of Facility ack Fune lise Ave	. Du	ındalk,	Mary		nc. 21222 Approximate
8760,	cate be executed //Medical Examiner transit the burial-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any, Leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Atheroso Due to (or as b. Senile D Due to (or ac	lerotic a consequence o	Card							Interval Between Onset and Death
.O. Box 68	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		opic pregna her (s <i>pecif</i> y					Date of delive Month	ry Day Year
S, G	The law requires that the tee has been signed by though 2 should be detached.	by	Part II. Other significant conditions	contributing to death b	ut not resulting in	the under	rtying cause	given in Part I.		T .	acco use co		e cause of death?
al Reco		Completed								24a. Was ar autopsy perform 1 Yes 2	,	D. Were autop prior to con death? 1 Yes	psy findings available apletion of cause of
Division of Vital Record	ding Ph h. After th funeral	ation: To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ▼ Nô 27. Manner of Death 12. Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injui		me of jury	28c. I	O+	sing Home	Check only one 5 Reside d. Describe hor	nce 6 🗆 O)
Divis		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	ury - At home, fair c. (Specify)	n, street,	factory, offi	се	28	f. Location (Str City or Town,	eet and Nur State)	nber or Rural	Route Number,
	To the Hospital or within 24 hours after to the Funeral Dir completely filled in	Medical	one)	nysician: To the best of miner: On the basis of and manner sta	examination and	death occ	curred at the	e time, date and ny opinion, death	place, and occurred	d due to the ca at the time, da	use(s) and r te and place	manner as sta e, and due to	ited. the cause(s)
	To To con		29b. Signature and title of certifier	E Name	_		D3	ense number 30641			d. Date sign	ned (Month, D	200 4
	5		30. Name and address of person who Ramesh Sabapathi	201 - 109 E	Back Rive			ad Bal	timo	re, Mar	y1and	2122	1
	Sta Registr		31. Date filed (Magth, Dev., Year)	32 Registra	r's Signature	14	oak.						

			For Stete Registrar	State of Ma		ertificate of Dealertificate			giene2	004	18491
	Physicia	an	1. Decedent's Name (First, Middle, La	catheri:	ne Mary	Matan		2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give		1.4.2.1	4b. City, Town, or Loca	ation of Death	June 9	-	4 unty of Death	1:37 P ^M
	Examin	er	2031 Jasmine Ro			Dunda				Balti	more
П	Funeral		5. Social Security Number 6. S	DM APTE	e (In yrs. last birthday		Jnder 24 Hrs. ours Min.	8. Date of Birt (Month, Da	v. Year)	9. Birth	place (State or Foreign intry)
	Director		210-26-05/9	- C	69 Yrs.			Aug. 2	2,193	4 Pen	nsylvania
	wo.		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	Location					10d. Inside City Limits
	Mary a-f sh	tor	Maryland Balt	imore			Dunda	1k			1 ☐ Yes 24∑XNo
	th the	Director	10e. Street and Number			10f. Zip Code			_	of What Cou	-
	ath w		2031 Jasmine Roa		r : u o 10	21222				ed Sta	
	items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑	1	. Was Decedent of Hispan If Yes, specify Cuban, Me	exican, Puerto	Rican, etc.)		Race - Amer Black, White	
	72 hours after death with the Marylend natural; or items 23a or 28a-f show dical Examinat must be motified at	þ	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No Sp	pecify:		Spi	ecify: Wh	ite
	72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dec	edent's Usual Occupation re kind of work done during DO NOT use retired)	g most of worki	ing	16b. Kind	of Business/I	ndustry
1	within	шp	Elementary/Secondary (0-12)	College (1-4or 5)+)				01 - 11		
2	be filed within 72 hatal Hygiene. Id other than "natule event, it a Medical		8 Years 17. Father's Name (First, Middle, Last)		Seamtress 18.	Mother's Name	(First, Middle,			anufacturing
3	lid be lental rked c	To Be	Stanley Kru	car				Cat	herine	e Supe	ck
	should Name	_	19a. Informant's Name/Relationship	Type, Print)		iling Address (Street and N		al Route Numbe	er, City or To	wn, State, Z	ip Code)
,	and 2 eelth m 27 i		Mr. Paul Matan	/ Son		35 Eastfield		Dundal			
5	ges 1 if of H if ite		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 [ematory or other place)	1	Date		on - City or T	
	permit. Peges 1 and 2 should be filed withi Department of Heelih and Mental Hygiene. Importent: If item 27 is marked other than any injury or other treumatic event, I an M 2006.		'4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice			Service Cor 22. Name and Address of		4/2004	Tows	on, Ma	ryland
2	Departiment of the service on the service on the service on the service on the service on the service of the se) Say ration of the latest solving Electrical Solvi			Duda-Ruck Fu 7922 Wise Av	ıneral				
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each li	the death. Do not e	nter the mode of dying, su	ch as cardiac c	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a	HY	BYIA					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	cel (60.00	n HA			D. D
		er	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a consequence of):	CEU C	187661	NOF ITS	-	-	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	^							
5	an en		resulting in death) Last	Due to (or as	a consequence of):						
	The law requires that the death certificate be executed ate has been signed by the attending physician end page 2 should be detached for use as the burial-transit	edicat	•	d							
5	ding p		IF FEMALE:	23c. If yes, outcome	of pregnancy				024	Date of dall	
ב	eath certifi attending I for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			230.	Date of delive	Day Year
į	res that the de signed by the a l be detached f	hyst	1 Yes 2 No 9 Unknown	9□ Unknown							
,	s that gned b	by P	Part II. Other significant conditions	-	_		Part I.				the cause of death?
5	w require been sign	ted	LOVEND	RY ARTE	ع داه م	mgs		101	res 2 ☐ N	o 3 □ Pro	bably 4 Unknown
ב נו	a law r has be	Completed				· · · · · · · · · · · · · · · · · · ·		24a. Was autop		4b. Were aut prior to co death?	opsy findings available ompletion of cause of
2	n: The							1 ☐ Yes	2 No	1 Yes	2□ No
2	siciar certif irecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 ER/Outpati	Other		n <i>(Check only o</i> me 5. ⊒-Resi t		Other /Spec	(6x)
5	tending Physician: The lavieath. foath. tor: After this certificate has the funeral director, page 2	[27. Manner of Death	28a. Date of Inju (Month, Da	ry 28b. Time	of 28c. Injury at		28d. Describe I			(iy)
5	ath. r: Afte	atlo	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	on .	y Year) Injury	M 1 ☐ Yes	2 □ No				
2	or Atterde Directo	ertiflcation;	3 Suicide 6 Could not a determined	286. Place of Inj	ury - At home, farm, s c. (Specify)	street, factory, office		28f. Location (5 City or Tox		umber or Rui	ral Route Number,
ב	pital c	0	20a Cartifica 4 Th Cartiffica B	hydicians To the book	of my knowledge, de-		ata and alam	and due to the			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	edical			f examination and/or	ath occurred at the time, do investigation, in my opinion					
	To the To the To the To the To the To the Comp	Ř	29b. Signature and title of certifier	1.45		29c. License nun		I		gned (Month	
) July	MD		D553	06		JUNE	10,	2009
	10			M.D. 91	OG PHILAD.	ELPHIA R.D.	SUITERA	b BAL	T. MD	2123	37 .
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 4 2004	32. Registr	ar's Signature	porks					
					7 7						

		1	For State Registrar	State of Marylar	nd / Dep	artme		alth and I	-	raiene .	104	18	492
	Physici /Medic Examin	al	Decedent's Name (First, Middle, La. Secility Name (If not institution, gives)	JOSEPH H. e street and number)	McDA	NIEL 4b. City		cation of Death	2. Date of Domestin	12, 20 4c. Count	of Death	3. Time o	
Ī	Funeral Director				. last birthday, Yrs.) If Under		Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D 08-04		9. Birthpl Coun VIF	TORE lace (State try) RGINIA	or Foreign
	ms 23a or 28a-f show	ector	Usual Residence of Decedent 10a. State 10b. County MD. BALTI 10e. Street and Number		ity, Town or L	,	ESSEX ip Code			10g. Citizen of			City Limits
	s 23a or	Funeral Director	ONE EASTERN	BOULEVARD	15 13		2122		necify Ves or N	U. S	A.		
12-003p	tural, or item	þ	11. Marital Status 1 Never Married ACX Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 — Yes 2 2 100 If Yes, Give Year or Dates:		1 🗆 Yes	३(∑ No S	Specify:	pecify Yes or N o Rican, etc.)	Bla Specif	ck, White,		
Ç121	within 72 ene. than "na he Madic	Completed	15. Decedent's E (Specify only highest grave) Elementary/Secondary (0-12) 12 YEARS	ducation ade completed) College (1-4or 5+)	16a. Dece (Give life.	edent's Usi e kind of w DO NOT WELDI		n ng most of wor	king	BETHLE		otestry STEEL	CORP
⊑ .	nould be filed I Mental Hygi narked other natic event, I	To Be C	17. Father's Name (First, Middle, Last, PALMER MCDANI	EL	10b Moil	in a Addras		ELLA	McDANI	e, Maiden Sumai EL per, City or Town	ĺ	Code	
	s 1 and 2 sr f Health and item 27 is n other traun			(GUARDIAN)	417 R	REGES	TER AVE			E, MARYLA	ND, 2	21212	
_	Page ment o ant: # ury or		20a. Method of Disposition 1 □ Burial 2XX cremation 3 □ 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lices	(y) H	Place of Disp cemetery, cre LLTOP	SERV	ICE COF	of Facility	15-2004	TOWSON,	MARYL	AND, 2	n
g	Depart Import eny inj		P. M. But		R	RUCK	TOWSON	FUNERA		INC. TOW	ISON, M	D.212	204
	mysician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Finel disease or condition resulting in death)	plications that caused the dear one cause on each line. Paric a	ins) J. R.Ci.		or respiratory a	rrest,		Approxima Interval Be Onset and	tween Death
/60,	icate be executed physician and sthe burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b									
P.O. Box 68/	ath certif ttending for use as	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fel 4 Pregnant at time of 9 Unknown	al death 3	□Ectopic □ Other (s	pregnancy specify)				ite of delive	-	Year
rds, P.	w requires that the de been signed by the a should be detached t	ed by Ph	Part II. Other significant conditions of		sulting in the		cause given ii	n Part I.		tobacco use con Yes ŽŽNo		e cause of ably 4	
Division of Vital Records,	i Physicien: The law re ir this certificate has be aral director, page 2 sho								1 Tes	ppsy ormed?	Were autor prior to con death? 1 ☐ Yes	npletion of	available ause of
	ysicien is certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2(X)No	Hospital: 1 Inpatient 2[] ER/Outpatie	ent 3 🗆 🗅	Lou		ith <i>(Check only</i> ome 5 ☐ Res	one) idence 6 □Ott	ner (Specify)	
o uoi	anding Phath.		27. Manner of Death 1XX\taural 5 \(\to \text{Pending} \) 2 \(\to \text{Accident} \)		28b. Time Injury	of M	28c. Injury at Work? 1 ☐ Yes	2 □ No	28d. Describe	how injury occur	red		
Divis	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifics completely illied in by the funeral director,	Certification;	3 Suicide 6 Could not be determined	building, etc. (Spec	eify)				City or To	(Street and Numi wn, State)			nber,
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	Medical	29a. Certifier XIX Certifying Pl (Check only one) 2 Medical Exa	hysician: To the best of my kr miner: On the basis of examir and manner stated.	nowledge, dea nation and/or i	nvestigation	d at the time, on, in my opinion	date and place on, death occu	, and due to the rred at the time	cause(s) and m , date and place,	anner as sta and due to	ated. the cause(s)
	To the within To the Comp.	M	29b. Signature and title of certifier			2	9c. License nu D43			29d. Date signe	d (Month, L	Day, Year)	
	6		30. Name and address of person who		m 23a) (Type - 10 ℃	Print)			Necle	12 cl	Bal	712 1000	21
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature		E.						

ORIGINAL

		1	State of Maryland / Department of Health and M State of Maryland / Department of Health and M Certificate of Death		giene Reg. No. 2004	18493
	Physicia		1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month		3. Time of Death
	/Medic	al	Donald Guy Malloy, Jr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	June I	1, 2004 Year 4c. County of Deat	5:28 AM
	Examin	er	011 1 1 1 77 1 0			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birtl	h 9. Birt	hplace (State or Foreign
	Director		212-04-6815 1AM 2 F 25 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day Sept.	9, 1978 Ma	ryland
-	and w	-	Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Maryla f sho	5	Maryland Harford Edgewood			1 ☐ Yes 2 🛣 No
	28a-	rect	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	ountry?
	h with	ai D	3487 Albantown Way 21040		U.S.A.	
	r dea	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	s afte	by Fi	1 ☐ Never Married 2 A Married 1 ☐ Yes 2 No 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: Wh	ite
8	within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28s-f show the Madical Examinations I.ve recitiod at	ted t	15 Decedent's Education 16a Decedent's Usual Occupation		16b. Kind of Business/	Industry
215	thin 7: e. en "n	Completed	(Specify only highest grade completed) (Give kind of work done during most of working the both states of th	ng		
21	filed will Hygien other th	Con	12 Years N/A Installer Specialist	(Fina Middle	Office Fur	rniture
الابره Maryland 21215-0036	ould be fil Mental H varked ott	Be	17. Father's Name (First, Middle, Last) Ronald Malloy, Sr. 18. Mother's Name Mellod	y Gallo		
Z Z	should ind Men s marke umatic	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura			Zip Code)
	and 2 s ealth ar m 27 is ner treu		The state of the s		The deleted	
Ø 8	ss 1 a of Hea item		Ronald Malloy, Sr. 3487 Albantown Way E 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Comparison of Disposition (Name of cemetery, crematory or other place) 6/14	704	20c. Location - City or	Town, State
S E	Pages ment of I ant: If its ury or o		A Donation 5 Other (Specify) Baltimore Washington Crema			
5:28. Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-1 show any injury or other treumatic event, the Medical Examinational by Incilling at ODEs.		21. Signature of Fuceral Service Licensee 22. Name and Address of Facility Bradley Ashton Mat 2134 Willow Spring	thews F	uneral Home Dundalk, M	Inc.
6	TO SERVE		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or heart failure. List only one cause on each line.	r respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate base (Final disease or condition a Acufe Stoke			Onset and Death UNCOKS
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
4		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Create of Kight)			
4	ate be executed hysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease of with) that initiated events c.			
2004	a exectan an an urial-tr	Еха	resulting in death) Last			
2CA 8760,	ate be hysici the bu	dical	d			
) XO	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of del	iven.
m	atten atten	cian	23b. Was decedent pregnant in the past 12 months? 1		Month	Day Year
岁。	it the de by the tached	hysi	9 Unknown			
JUNE S, P.O. I	as tha	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to	
ecord	w require been si	ted	Astro cytoma	1 🗆 Y	'es 21 Pr	obably 4 Unknown
Reco	aw as b	Completed		24a. Was a autop perfor	sy prior to death?	utopsy findings available completion of cause of 2 No
4 ULC Vital	iician: Th certificate rector, pag	0	25. Was case referred to medical 26. Place of Death			2 140
	Phyaician: this certific ral director.	To B	examiner? 1 Yes 2 No	me 5 Resid	lence 6 ther (Spe	city) fospice
Zon	ding Phy I. After thi funeral		1 Natural 5 □ Pending (Month, Day Year) Injury Work?	28d. Describe h	ow injury occurred	. ,
ALD 1	Attending r death. ector: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be adelegating and determined determined	28f Location /9	Street and Number or Ru	iral Boute Number
CNALC	I or Attendatter deatt Director:	Certification;	4 Homicide determined determined building, etc. (Specify)	City or Tow		and House Herrison,
2	To the Hospital or Atlanding Phyaician: The within 24 hours after death. To the Funeral Director: Atlar this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and manner stated.			
,	To the within 2 To the comple	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mont	
	ix		M Anthy Mily, no D25205		June 11,	2006
-	۷ \		30. Name and address of person who completed cause of death (fam 23a) (Type, Print) W. A - R. (Ry G BMC G 701 N. Charle S)	to Bo	elto. Mid	21284
:	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature September 19 19 19 19 19 19 19 19 19 19 19 19 19			

DHMH 17 Rev 1/2001

-3839 D	1- State of Maryland / D State of Maryland /	epartment of Health and M 722/04 TH Certificate of Death	lental Hygien	
Physician	Decedent's Name (First, Middle, Last) MICHELLE ANNA MARKEY		2 Date of Death	ay Year 3. Time of Death
/Medical Examiner	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL	4b. City, Town, or Location of Death BALTIMORE CITY	JUNE 4	9, 2004 9:25p M c. County of Death N/A
Funeral Director	5. Social Security Number $220-35-0782$ 6. Sex $1 \square$ M $2 \square$ F $1 \square$ Y Usual Residence of Decedent		8. Date of Birth (Month, Day, Yea, June 19 1	·
death with the Maryland rms 23c or 28a-f show rmstler ruitified at	10a. State 10b. County 10c. City, Town Md. Anne Arundel Co. Pasad			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
with the Mar E or 28a-f si Let indiffed Director	10e. Street and Number 1207 Hillside Road	10f. Zip Code		itizen of What Country?
<u>5</u> 2 3 5	11. Marital Status 1 \(\times \) Never Married 2 \(\times \) Married 3 \(\times \) Widowed 4 \(\times \) Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\times \) Yes 2 \(\times \) No If Yes, Give Year or Dates:	21122 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:		.S.A. 14. Race - American Indian, Black, White, etc. Specify: white
5-0 72 ho 72 ho	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during most of worki life. DO NOT use retired)	G G	Kind of Business/Industry eorge Fox iddle School
ore, Maryland 2121 ss 1 and 2 should be filed within of Health and Mental Hygiene, item 27 is marked other then other treumatic event. Ihs Me	17. Father's Name (First, Middle, Last) Richard R. Markey	18. Mother's Name	(First, Middle, Maider SHIRLEY MA	
	19a. Informant's Name/Relationship (Type, Print) Richard R. Markey (Father) 19b. M	Mailing Address (Street and Number or Rura 07 Hillside Road Pasa	Route Number, City adena, Md.	or Town, State, Zip Code) 21122
Baltimore, permit. Pages 1 ar Department of Hea Importent: If item any injury or other anger.	1 X Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Glen Ha	or or other place) 06/16 aven Mem. Pk.Maus.	/ N/i	ocation · City or Town, State n Burnie, Md.
Ball permit Depar Impor any in any in	21. Signature of Funeral Service Licensee	²² McCully Polyniak 3204 Mountain Roa	Funeral Ho d. Pasaden	me P.A,
Medical Examiner	23a. Part Finter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	IURIES	respiratory arrest,	Approximate Interval Between Onset and Death
3760, ate be execute hysician and he burial-trans	cause. Enter Underlying Cause (unsease or injury that initiated events resulting in death) Last C			
the death certification of the death certification of the attending the death of the as as in the death of th	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
S, es the igner be d	Part II. Other significant conditions contributing to death but not resulting in th	e underlying cause given in Part I.		ise contribute to the cause of death?
I Rec The law ate has b page 2 st	25. Was case referred to medical		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? Yes 2□ No
To To	examiner? 1 XYes 2 No Hospital: 1 Inpatient 2 ER/Outpa			S ☐ Other (Specify)
Olvision or Attending after death. Director: After in by the fune	27. Manner of Death 1 Natural	Work? 1 ☐ Yes 2 KNo Street, factory, office 28	d. Describe how injure to the control of the contro	Number or Rural Route Number Fort Smallwood Rd
Hospi 4 hou Funer iely fill	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, do 2 Medicel Exeminer: On the basis of examination and/or and manner stated.	Bath occurred at the time, date and class, or	d due to the course (-)	and manner as stated. place, and due to the cause(s)
To the within 2 To the complet	29b. Signature and title of certifie	29c. License number OCME	29d. Date JUNE	a signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a) (Type S. R. HCHAP)	111 Penn Street, Ba	ltimore. M	arvland 21201
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	mely		

ORIGINAL

		1 - For State Registrar	State of Maryl	•		t of Hea e of De		F	leg. No. 2U	04 1849
Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last Norman D. Nicke 4a. Facility Name (If not institution, give	y, Sr.		4b. City,	Town, or Loc	ation of Death	2. Date of Dea Month		
Funeral Director	(C)	S. Social Security Number 6. Se	NWO	yrs. last birthday) Yrs.	If Under Months	1 Year If t	Jnder 24 Hrs. Durs Min.	8. Date of Birth June 27	130	9. Birthplace (State or Foreig Country) Maryland
Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo		City, Town or Lo Arbu						10d. Inside City Limit
s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mealth Hygiens. I fleating 15 a cr 28a-f show item 21a or 28a-f show other treumatic event, the Medical Examinar must be ruillised at	Funeral Director	10e. Street and Number 2216 Sulphur Spri 11. Maritaf Status	12. Was Decedent Ever i Amed Forces?	n U.S. 13.		21227	ic Origin? (S exican, Puerto	pecify Yes or No-	14. Race	nat Country? A. - American Indian, White, etc.
in 72 hours afti n"natural", or l	Completed by F	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edi (Specify only highest grace)	e completed)	I 16a, Dece	dent's Usua	I Occupation to done during e retired)		king	Specify:	White
d be filed within intal Hygiene. cad other than covert, the Me	Be	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) David M. Nickey	College (1-4or 5+)			Maker 18.	Mother's Nam		Constru Maiden Sumame,	
and 2 should be ealth and Mental m 27 is marked her treumatic ev	To	19a. Informant's Name/Relationship (7) John H. Nickey, S	on	35 L	ittle	(Street and N	Jumber or Ru Drive	ral Route Number Hanove	r, City or Town, Si	17331
t. Page rtment o rtant: If njury or		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify) 21. So halve of Funeral Service Licens	Lo	b. Place of Dispo cemetery, crea oudon Pa	rk Cei	metery	06-	16-04	Baltimo ansdowne	
Depa Impo Impo any I		23a Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ications that caused the cone cause on each line.		2719	Hammon	ds Fer	rv_Rd. L	ansdowne	
eath certificate be executed EMPA attending physicien and for use as the burial-transit	dical Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last	Due to (or as a con Due to (or as a con Due to (or as a con Due to (or as a con	sequence of):						
0 0 D	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time	etal death 3	⊒Ectopic pre ⊒ Other (spe				23d. Date of Month	,
ine taw requires mai me the taw requires mai the tas been signed by the page 2 should be detached.	by	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	inderlying ca	tuse given in	Part I.			ute to the cause of death?
(0)	e Completed	25. Was case referred to medical				26.	Place of Deal	24a. Was a autops perform 1 Yes 2	prid ned? dea 2 1 1	re autopsy findings available for to completion of cause of ath? Yes 2 No
ang rnys n. After this funeral dii	tlon; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Naturaf 5 Pending 2 Accident investigation	lospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatier 28b. Time o		Other	Hursing Ho	ome 5 ☐ Reside	ence 6 Other	
ore or Attending urs after death. In a lied in by the fune fune fune fune fune fune fune fun	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	ecify)				City or Towr	ı, State)	or Rural Route Number,
To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	(Check only 2 Medical Exami	sician: To the best of my ner: On the basis of exan and manner stated.	nination and/or in	vestigation,	in my opinion	, death occur	red at the time, d	ate and place, and	d due to the cause(s)
S S S S	~	29b. Signature and title of certifier. 30. Name and address of person who come address of	me Mr	lem 23a) (Type					-	Month, Day, Year) 2, 2004
Sta	•	31. Date filed (Month, Day, Year)	Phone 82. Registrar's Si	711Ma	den box		ice L	ane	, Baltu	2, 2004 MD2122

			For State Registrar	State of M	aryland / De _l	partment of Fertificate of			giene Reg. No. 2	004	18496
, ch	E .		Decedent's Name (First, Middle,	Last)				2. Date of Dea	ath		3. Time of Death
	Physicia							JUNE:	Day	Year	5:15 P. M
	/Medic Examin		4a. Facility Name (If not institution,			4b. City, Town, o	or Location of Death			unty of Death	7.17 -
	Examin	er	GLEN MEADOW RETI			GLEN	ARM		E	BALTIMO	RE
	Funeral		5. Social Security Number 6		ge (In yrs. last birthda		If Under 24 Hrs. Hours Min.	8. Date of Birt	h		lace (State or Foreign
	Director		216-18-6387 Usual Residence of Decedent	1□M 24□F	82 Yrs.	Months Days	Hours Min.	(Month, Da 5/30/1	922	PENNS	SYLVANIA
	yland		10a. State 10b. County		10c. City, Town or	Location				1	0d. Inside City Limits
	Mar	to	MD HARFO	RD	BEL	AIR					1 ☐ Yes 2 📉 No
	r 28g	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	itry?
	th will	a	1415 LOCH CARRO	ON WAY		21015	5		USA		
	dea	ner	11. Marital Status	12. Was Decedent Armed Forces		Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No		Race - Americ Black, White,	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, if a Medical Examination at notified at once.	by Funeral	1 ☐ Never Married 2 ☐ Marrie 3 🖾 Widowed 4 ☐ Divorced	If Yes, Give		1 ☐ Yes 2 ☒ No	Specify:				II T E
21215-0036	hour:	Q D		Year or Dates:		cedent's Usual Occup	nation		16b Kind /	of Business/Inc	
5	"nat	Completed	15. Decedent's (Specify only highest	grade completed)	(Gi	ve kind of work done DO NOT use retire	during most of won	king	TOD, KING	or Dusinessymi	Justiy
12	withir ane. than	m.	Elementary/Secondary (0-12)	College (1-4or	5+)	MEMAKER	-,		OL/NI	HOME	
	filed Hygir ther		12TH GRADE 17. Father's Name (First, Middle, La	ast)		MEMAKER	18. Mother's Nam	ne (First, Middle,		HOME mame)	
an	d be ental ked o	To Be	GEORGE BUEHLER				ELSIE	E LEHMAN			
Maryland	shou nd M mer umet		19a. Informant's Name/Relationshi	p (Type, Print)	19b. Ma	iling Addrass (Street	and Number or Ru	ral Route Numbe	er, City or To	r, City or Town, State, Zip Code)	
	alth a		JAMES C. PHIPPS	SO	N 14	5_LOCH CA	ERON WAY	EEL AI	R. MO	21015	
Baltimore,	of He of He Item		20a. Method of Disposition	Community of State	20b. Place of Dis	position (Name of rematory or other pla		Date	20c. Locati	ion - City or To	wn, State
Ĕ	Page nent c nt: M		1 Burial 2 □ Cremation 3 4 □ Dorfation 5 □ Other (Spe			PARK CEM	1. 6/14	1/2004	WOODI	AWN, N	ID
alti	mit. Dartm Dorta / Inju		21. Signature of Funeral Service Li	censee		22. Name and Addre	ess of Facility TH	É JOHNS	ON FUN	IERAL H	OME, P.A.
m	Depariment Department of the poores		Skather N.	Hanne		8521 LOCH	RAVEN BL	VD. TO	WSON,	MD 21	286
Г			23a. Part1. Enter the disease, or c	omplications that cause	d the death. Do not	enter the mode of dyi	ng, such as cardiac	or respiratory ai	rest,		Approximate Interval Between
	Pnysician	ĸ	Immediate Cause (Final Dest A I F F 11 1/2 F								Onset and Death
П	/Medical		disease or condition resulting in death)	- a.	s a consequence of):					-	10 / 12
ı	Examiner			. B	REAST	ADE	NO CAR	C1N0	MA		4 YEARS
	EN VIA	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or a	s a nonsequence of):						<u> </u>
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c							
60,	be executed ician and burial-transit	EX	resulting in death) Last	Due to (or a	s a consequence of):						
9/1		ical	•	d							
687	ntifica ng ph as th	Jed	IF FEMALE:								
Вох	death certificate t attending physic of for use as the b	Physician/Medic	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy						23d. Date of delivery Month Day Year		
B	the att	sicia	in the past 12 months?			Othar (specify)				MOHIM	Day 1841
P.0.	that the de ed by the detached	h	9 ☐ Unknowń				· · · · · · · · · · · · · · · · · · ·	D:44			
	res that igned I be det	þ	THE STAN WILLS DISCORDED							cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown	
ord	w requir been si should							10	res 2 DAN	10 3 Proc	abiy 4 Johknown
Vital Records,	2 55 00	Completed		0F C		2)(2	13450	24a. Was autop	an 2	4b. Were auto	psy findings available mpletion of cause of
m		TO.	HYPO AL	BUMINE	MIA			perfo 1 ☐ Yes	rmed? 2⊠No	death?	2□ No
ita	E # 5	To Be (25. Was case referred to medical examiner?				26. Place of Dea	ith (Check only o	ne)		
of V	hysicia nis cert i direct		1 ☐ Yes 2 █ Ño	Hospital: 1 Inpat	ient 2 ☐ ER/Outpa	IBIT 3 DOA		lome 5 Resid	dence 6	Other (Specif	y)
0			27. Manner of Death ↑ SNatural 5 ☐ Pending	28a. Date of In (Month, D	jury 28b. Time a <i>y Year)</i> Injur	y Wo		28d. Describe	now injury or	ccurred	
Division	Attending it death.	Certification:	Investigation M 1 Yes 2 No								
ž	r Att ter de irect	TILL	3 Suicide 6 Could no 4 Homicide determin	289. Flace of II	njury - At home, farm, etc. <i>(Specify)</i>	street, factory, office		28f. Location (S City or Tox		umber or Rura	il Route Number,
	ital o irs af ral D										
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical E	Physician: To the bes xeminer: On the basis	of examination and/or	eath occurred at the t investigation, in my	ime, date and place opinion, death occu	, and due to the irred at the time,	cause(s) and date and pla	d manner as s ace, and due to	tated. the cause(s)
	the lin 2 the mplet	Med	one) 29b. Signature and title of cell frier	and manner s	stated.	29c Licen	ise number		29d Date s	igned (Month,	Day Year)
7	5 ₹ 5 8		290. Signature and title of Chimer	BAMAN	11 / 22 24 4					,	-004
7	/				A KOPACA						/
	5		30. Nagre and address of person w	no completed cause of	death (Item 23a) (Ty	Por L A I	1- (DIRC	RAANE	#150	9 13 AC	1) 21123
10			31. Date filed (Month, Day, Year)	32 Regis	trar's Signature	100-110	1 (-C)	11011 107	1 '	i M	V 01220
	St Regist		JUN 1 4 200								
D	HMH 17 Rev 1/2	_	JUN 1 4 ZUL	14 Maleira	S. Jan						
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			For	State of Ma	ryland / Depa						igible.	10107			
		•	1 State Contificate of Dooth							eg. No.	.004	1849/			
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Joseph Albert Price Sr.					2. Date of Dea Month June	Day	Year)4	3. Time of Death 8:46 P M				
k	Examir		4a. Fecility Name (If not institution, give	e street and number)		4b. Cit	y, Town, or Loca	tion of Death		4c. County of Death					
			3113 Garden Aver				Baltimor		1		Baltimo				
	Funeral Director		214-20-2880	Sex 7. Age	78 Yrs.	Month		nder 24 Hrs. urs Min.	8. Date of Birth Month, Pay 1/26/15	26 Year)	9. Birth Cou Mary	place (State or Foreign intry) yland			
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation						10d. Inside City Limits			
	sa-f aho	Funeral Director		imore	Baltimo		ip Code			Inc. Citizen	of What Cou	1 ☐ Yes 2 🔯 No			
	with ti	吉	10e. Street and Number 3113 Garden Aver	1116		101. 2	2123	4		7	J.S.A.	and y :			
	ns 23	era	11. Marital Status	12. Was Decedent E	ver in U.S. 13.	Was Dec			ecify Yes or No- Rican, etc.)		Race - Amer				
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f ahow important: If item 27 is marked other than "hat an interest call the multiple at a power, it a Medical Examinar cutal be multiple at other.	þ	1 ☐ Never Married 2 ☐ Married 3 🔁 Widowed 4 ☐ Divorced	Armed Forces? 1	0		ecify Cuban, Me		Rican, etc.)		Black, White ecify: Wh:				
0-19	72 ho	ted	15. Decedent's E	ducation ade completed)	16a. Dece	dent's Us	sual Occupation work done during	most of work	ina	16b. Kind	of Business/I	ndustry			
21	within and the state of the sta	Completed	Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT	use retired) Jorker			C.A.	. 1 C				
S	Hygier Hygier other th		12 17. Father's Name (First, Middle, Last	14				Mother's Name	e (First, Middle,		own, State, Zip Code) yland 21234 tion-City or Town, State imore, Maryland uneral Home Inc.				
Maryland	should be fi ind Mental H is marked of umetic ever	To Be	Clarence Price	,			10.1	Edi							
a L	2 sho and is mu		19a. Informant's Name/Relationship												
	1 and 2 Health tem 27		Steven Price/Son	<u> </u>					ltimore,						
Baltimore,	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 X8urial 2 Cremation 3		20b. Place of Disponentery, cre										
Ë	t. Partmen rtant: njury		* 4 □ Donation 5 □ Other (Special		Moreland				2/04						
Bal	My Medical Department of H Department of H Important: If its any injury or of on the many injury or of the man		21. Signature of Funeral Service Lice	1908					^N Miller-Dippel Funeral Home ad Baltimore, Maryland 21206						
63		177	23a, Part1. Enter the disease	plications that sauced							yrand	Approximate			
			23a. Part1. Enter the disease shock, or heart failur st only Immediate Cause	one cause on each lin	one cause on each line.				2016	0					
			disease or condition resulting in death)	a. Due to (or as a consequence of);				<u>C</u>		lyrs					
24	Examiner		icolognois conditionand nathod							1					
Ш	8	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):											
	be executed sician and burial-transit	Examiner	that initiated events	c											
60,	be execut ician and burial-trar	EX	resulting in death) Last	Due to (or as	consequence of):										
6876	ate be hysic the be	lical	d												
, e	death certificate e attending phys	Mec	IF FEMALE:	22a li vas outcoma	of oregranmy						Date of Jali				
Вох	ath cer attendir for use	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	lc. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)				230	. Date of delin Month					
	he de / the ched	ysic	1 Yes 2 No	9□ Unknown	51 55411.		opoony/								
P.0	v requires that the de been signed by the should be detached	H-	Part II. Other significant conditions	contributing to death be	it not resulting in the	underlyin	g cause given in l	Part I.	23e. Did to	bacco use	contribute to	the cause of death?			
ds,	uires sign ld be	d b	Autoimmu	ne hear	Dustic	H	nalor	ria	1 🗆 Y	es 2 🗵	io 3□Pro	bably 4 Unknown			
00	law req as beer 2 shou	lete	Achaltosis					24a. Was a		24b. Were autopsy findings available					
Re	0 - 0	Completed by Physician/Medic	Instate (ances.			autop perfor								
ta	ician: Th	a	25. Was case referred to medical	26. Place of De				Place of Deat	eath (Check only one)			20.00			
>	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filed in by the funeral director,	To B	examiner? 1 Yes 2 No					☐ Nursing Ho	g Home 5 ⊠Residence 6 □Other (Specify)						
0			27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injury 28b. Time of Injury			of 28c. Injury at Work?		28d. Describe how injury occurred						
jo		atic	2 ☐ Accident investigation	on		М									
Division of Vital Records,	r Atte	Certification:	3 Suicide 6 Could not determined		iry - At home, farm, si c. (Specify)	treet, fact	ory, office		28f. Location (S City or Tow		lumber or Rui	ral Route Number,			
	urs afte														
	Hospital	edical		hysician: To the best of miner: On the basis of and manner sta	examination and/or is										
the color of the c						29c. License nun				d. Date signed (Month, Day, Year)					
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					6/1	0/04									
	lex'		30. Name and address of person who		eath (Item 23a) (Type	Print)	d Rd	. B.	altmo	nl	MD	21234			
		ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	1									
	Regist	rar	UIM 1 A 200A	12		100	Kal								

		1	State of Maryland / De 1 - State of Maryland / De 1 - State of Maryland / De Registrar AMEND ITEM #5 PER FH G834 8 P	partment of Health and M ertificat ल of Death		ene g. No.2004 18499
ı	Physici		1. Decedent's Name (First, Middle, Last) Mary J. Rinker		2. Date of Death Month	Day Year 1:10-PM
	/Medic Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	00.10	4c. County of Death
1			Union Memorial Hospital	Baltimore City Bay If Under 1 Year If Under 24 Hrs.	9 Date of Righ	N/A
	Funeral Director		062 12 1209 6. Sex 1 □ M 2	Months Days Hours Min.	8. Date of Birth (Month, Day, 1) Dec. 18,	Year) 9. Birthplace (State or Foreign Country) Pennsylvania
			Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	Location		10d. fnside City Limits
	Aanyla f ehov	ō				1. Yes 2 □ No
	r 28a-	irect	Maryland N/A Baltimo	10f. Zip Code	10	g. Citizen of What Country?
	23a o	raiD	830 W. 40th Street Apt. 265	21211		U.S.A.
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f ehow amy injury or other traumatic event, ite Medical Experiment be notified at Once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Sp ff Yes, specify Cuban, Mexican, Puerto □ Yes 2 No Specify: 	ecity Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
2-0	72 ho	eted	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work	ing 1	6b. Kind of Business/Industry
121	within ene. than '	idmo	Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Own	e. DO NOT use retired)		Restaurant
d 2	e filed al Hygi other vent, I	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, M	
ylar	Menta Menta arked	ToE	William Henry Jenkins		lizabeth	<u>_</u>
, Maryland 21215-0036	and 2 sh ealth and m 27 is m		Martha Rinker - Daughter 34	ailing Address (Street and Number or Rur. 20 16th Street N.W.	. Apt. 6	
Baltimore,	Pages 1 ment of H ent: If ite ury or ott		1 Buriaf 2 X Cremation 3 Removal from State	re Washington Cremat	5/04 cory, Inc	Laurel, MD
Balt	permit. Departr Importe any inju		21. Signature of Funeral Septice Licensee	22. Name and Address of Facility Bradley-Ashton-Mat 2134 Willow Spring	gs Road	Dundalk, MD 21222
8760,	Physician /Medical Examiner property with principle and property with principle and property with the principle and property with the principle and property with the principle and property with the property of the property	dical Examiner	23a art1. Enter the disease, or complications that caused the death. Do not shock, or heart fafure. List only one cause on each fine. Immediate Cause (Finaf disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or inpury that initiated events resulting in death) Last Due to (or as a consequence of) c	n failure		Interval Between Onset and Death Four days
.O. Box 68	Attending Physician: The law requires that the death certifical rideath. sctor: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as it	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 No 9 ☐ Unknowe 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
4	ires that signed b		Part ff. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
Division of Vital Records,	fhe law requir te has been si age 2 should	Completed			24a. Was an autopsy perform	prior to completion of cause of
ital	strifica ctor, p	BeC	25. Was case referred to medical examiner?		th (Check only one	
on of V	To the Hospital or Attending Physician: The law within 24 hours effer death. To the Funerel Diractor: After this certificate has completely filled in by the funeral director, page 2	70	1 ☐ Yes \$1 No	e of 28c. Injury at	ome 5 Resider 28d. Describe how	nce 6 □Other (Specify) winjury occurred
Divisi	al or Atten s efter deat Il Diractor: od in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of fnjury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
	To the Hospital or within 24 hours effe To the Funerel Dirt completely filled in I	edicai (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, conduction and conduction a			
	To th within To th compl	Me	29b. Signature and title of certifier	29c, License number		d. Date signed (Month, Day, Year)
	,0		► Vautiguy, M.D.	AT2438946	7	Tune eleven 2004
	\		30. Name and address of person who completed cause of death (ftem 23a) (T) A 01 East University Boulevasco	Baltimore, Ma	uyland	21218
	Sta Regist	ate rar	31. Date fifed (Month, Day, Year) 32. Registrar's Signature	Sports		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [] 18500 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death I. ROSEN MIRIAM **Physician** JÜNE 2004 6:35 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOSPICE OF BALTO. - GILCHRIST CENTER TOWSON BALTIMORE Date of Birth Month, Day, Year) AUG II, 1921 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1□ M 2 F Days Hours NEW HAMPSHIRE 82 Director 019-14-6381 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or Items 23a or 28a-1 show othar traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director N/A BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7111 PARK HEIGHTS AVE., APT. 701 21215 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, et 1 Never Married 2 Married WHITE 1 Yes 2 No Specify: by 3 □ Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mantal Hygiene. Elementary/Secondary 20-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi Be LEVENTHAN **ESTHER** GOLDSTEIN BENJAMIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ILENE MAGAZINER (DAU) 6 FALLING LEAF CT. OWINGS MILLS, MD of Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of H Important: If ite any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON (CHIZUK AMUNO) 6/11/04 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Lipensee 21208 8900 REISTERSTOWN RD. PIKESVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER Physician month disease or condition resulting in death) /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy Yes Hospital or Attending Physician: 24 hours after death. Funeral Diractor: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 25205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Balfo. Md 21208

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year) JUN 1 4 2004

WIRIAM HOSEN June 9,2004 069

6701

G-Bon (

32. Registrar's Signature